

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07123

## CERTIFICATE OF DEATH

07109

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>		c. LENGTH OF STAY IN 1b <b>21 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7302 Dunmanway</b>		d. STREET ADDRESS <b>7302 Dunmanway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>AUSTIN</b>		First	Middle	Last	4. DATE OF DEATH <b>ACHE</b>	Month	Day	Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1885</b>	9. AGE (In years last birthday) <b>71</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hoist Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Erection</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Thomas Ache</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Lynn</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>022-10-552</b>		17. INFORMANT <b>Anna M. Ache</b>		Address <b>7302 Dunmanway, Dundalk</b>		
No								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420.0</b>		<i>Congestive heart failure</i>				INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	<i>Arteriosclerotic heart disease 5 yrs.</i>					
(c)		DUE TO						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that I attended the deceased from <b>6-12-57</b> to <b>7-1-57</b> , that I last saw the deceased alive on <b>7-1-</b> , 19 <b>57</b> , and that death occurred at <b>58</b> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Tal. P. Wong</i>		ADDRESS (Street, city or town, state) <b>6801 Belair Rd., Baltimore, Md.</b> DATE SIGNED <b>Med. 7/3/57</b>						
PHYSICIAN'S NAME (Type) <b>WYMAN K. WONG</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/5/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hellertown, Pennsylvania</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walt Chappie Bradley, Inc.</i>		ADDRESS <b>Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR <b>Date 11 8 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Jm. Kelly</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF JUSTICE - WASHINGTON  
CERTIFICATE OF DATA

BUREAU V. L.

JUL 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07136

07110

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb 2124146 716157		d. STATE <b>M.D.</b> b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSP.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		f. STREET ADDRESS <b>641 N. AUGUSTA AV., BALTO., 29</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First	Middle	Last	4. DATE OF DEATH Month <b>July</b> Day <b>6,</b> Year <b>1957</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>11-2-65</b>	9. AGE (In years last birthday) <b>91</b> yrs.	I. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Stock Clerk, Hopper McGaw</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>M.D.</b>	
13. FATHER'S NAME <b>FREDERICK ALBRECHT</b>		14. MOTHER'S MAIDEN NAME <b>WILMINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. LOUISA MOND 641 N. AUGUSTA AV., BALTO. 29</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)  Generalized Arterio Sclerosis. Malnutrition Dehydration Hemorrhage chest left Arterio sclerosis Senile Psychosis 19 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION MENTIONED IN PART I(a) <b>903.7</b> Fall on hospital ward					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall on hospital ward</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9 a.m.</b> 6/17/57		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b> (County) <b>Catonsville</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>  ACTUAL SIGNATURE <b>J. E. McGrath</b> EXAMINER'S NAME (Type) <b>J. E. McGrath M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jul. 8/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>London Park Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Balto. Md.</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>7/8/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

BUREAU V. S

JUL 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07137

## CERTIFICATE OF DEATH

07111

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NOTCH CLIFF NEAR TOWSON</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO RURAL TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENARM ROAD</b>		d. STREET ADDRESS <b>GLENARM ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>SISTER MARY BENONITA ALLMANN</b>		First	Middle
		Last	
4. DATE OF DEATH <b>JULY 27 1957</b>		Month	Day Year
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>MARCH 24 1884</b>		9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>	11. BIRTHPLACE (State or foreign country) <b>GATES, NEW YORK</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		Address	
13. FATHER'S NAME <b>JACOB GEORGE</b>		14. MOTHER'S MAIDEN NAME <b>JULIANA DOERNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT <b>SISTER M. PETER FOURIER</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO <b>350X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) DUE TO lying cause last. <b>PARKINSON'S SYNDROME</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>493X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.                          19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. 1501 YORK RD. TOWSON, MD.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 1953</b> , to <b>JULY 1957</b> , that I last saw the deceased alive on <b>JULY 23 1957</b> , and that death occurred at <b>12:20 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>CHARLES F. O'DONNELL</b>		ADDRESS (Street, city or town, state) <b>CHARLES F. O'DONNELL</b> DATE SIGNED <b>7/22/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-30-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Villa Maria Cemetery, Notch Cliff, Towson, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Towson, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geiler</b>		ADDRESS <b>901 S. CONKLING ST., BOSTON, MASS., 02140</b>	
		24a. REC'D BY REGISTRAR <b>JUL 29 1957</b>	
		24b. REC'D STAR'S SIGNATURE <b>Malek Gray</b>	

CERTIFICATE OF DEATH

NEBRASKA STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

BUREAU V.

JUL 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07112

07138

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>51</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines Nursing Home</b>		d. STREET ADDRESS <b>1725 Selma Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Sherman H. Atherton</b>	Middle	Last	4. DATE OF DEATH <b>July 1, 1957</b>	Month <b>July</b>	Day	Year <b>1957</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 8, 1881</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>		11. BIRTHPLACE (State or foreign country) <b>Worchester, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Gayland Atherton</b>			14. MOTHER'S MAIDEN NAME <b>Lucia Hesselton</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Mrs. Victoria Atherton 1725 Selma Ave.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Cerebral Vasculitis Accident - Hemorrhage</b> <b>Arterio sclerotic Hypertensive Disease</b>								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>447X</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Worchester</b>	(County) <b>Worchester</b>	(State) <b>Mass.</b>
21. I certify that I attended the deceased from <b>July 1, 1957</b> to <b>July 1, 1957</b> , that I last saw the deceased alive on <b>July 1, 1957</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1725 Selma Avenue, Baltimore, Maryland</b>								
DATE SIGNED <b>J. H. Hubbard, M.D.</b>								
ACTUAL SIGNATURE <b>J. H. Hubbard</b>								
PHYSICIAN'S NAME (Type) <b>Howard H. Hubbard</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-4-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b>			22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard 4107 Wilkens Avenue</b>				ADDRESS <b>4107 Wilkens Avenue</b>		24a. REC'D BY REGISTRAR <b>5 57</b>	24b. REGISTRAR'S SIGNATURE <b>John H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. A.

JUL 5 1957

REGELIV ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07113

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balt.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	c. LENGTH OF STAY IN lb 3½ yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3vo1-4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice	d. STREET ADDRESS 1802 N. Milton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma	First M	Middle Bafford	4. DATE OF DEATH 7 8 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/1880	9. AGE (in years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitress		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT	Address Admission Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cerebral Thrombosis Generalized Arteriosclerosis 15 yrs.		INTERVAL BETWEEN ONSET AND DEATH 2 mo.		
DUE TO (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from alive on		11/10, 1953, to 7/8, 1957, and that death occurred at 6:42 P.M., from the causes and on the date stated above.	ADDRESS (Street, city or town, state) Charles F.O'Donnell, M.D. 7501 York Rd. Baltimore, Md. DATE SIGNED			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		CHARLES F.O'DONNELL		CHARLES F.O'DONNELL		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-57	22c. NAME OF CEMETERY OR CREMATORIALoudon Park Natl.	22d. LOCATION (City, town, or county) BALTO	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Leonard J. Ruck 305 Harford.	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	DATE JUN 10 1957	

ATTACHMENT OF STATE DOCUMENTS

100-1000

BUREAU V. S.  
RECEIVED  
JUL 10 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07114

## CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>Aberdeen 12 31 2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Manor</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Frank E. Baker</i>		First <i>Frank</i>	Middle <i>E.</i>	
4. DATE OF DEATH <i>July 12 1957</i>	Month <i>July</i>	Day <i>12</i>	Year <i>1957</i>	
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 12, 1877</i>	
9. AGE (In years lost birthday) <i>79 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Canned Broccoli Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Food Livery</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Charles W. Baker</i>		
14. MOTHER'S MAIDEN NAME <i>Emma Michael</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs Frank E. Baker 34 W Belair Ave Rd.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5/2.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 - 5 weeks</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>				
(b) DUE TO <i>Cereosclerosis, General</i>				
(c) <i>Art. Sclerotic Heart Disease</i>				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>42.0</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 11, 1956</i> to <i>July 12, 1957</i> , that I last saw the deceased alive on <i>July 11, 1956</i> , and that death occurred at <i>7:15 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Warde B. Allan</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>6 E. Eager St Baltimore 7-13-57</i> DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/15/1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bakers Cemetery</i>	22d. LOCATION (City, town, or county) <i>Aberdeen Maryland</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>To the G. Barrings Aberdeen Md.</i>		ADDRESS <i>Aberdeen Md.</i>	24a. REC'D BY REGISTRAR DATE <i>July 16, 1957</i>	24b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

BUREAU Y.

1957 17 11

CE APPROVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07115

07141

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY ?				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN lb <b>44 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSP</b>		d. STREET ADDRESS <b>704 S. Port Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>GEORGE A. BANKARD</b>		First	Middle	Last	4. DATE OF DEATH <b>7/17</b>	Month	Day	Year		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/1886</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>JAMES BANKARD</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE RICHERT</b>		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic Heart disease (c)			INTERVAL BETWEEN ONSET AND DEATH	
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m.      19 p.m.            Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from <b>MAY 14, 1957</b> , to <b>JULY 17, 1957</b> , that I last saw the deceased alive on <b>JULY 17, 1957</b> , and that death occurred at <b>335 1/2 M</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Stella Wachler</b>		M.D. <b>Spring Grove State Hosp.</b>		ADDRESS (Street, city or town, state) <b>7-17-57</b>		DATE SIGNED				
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M.D.</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore County</b>		(State)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-19-57</b>		24a. REC'D BY REGISTRAR <b>JUL 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS		DATE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEAU V. S.

JUL 22 1957

EGELVÆ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07116

07142

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		c. LENGTH OF STAY IN lb <b>5 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		d. STREET ADDRESS <b>6008 Mannington Ave.</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6008 Mannington Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>E.</b> Middle <b>Barnhart</b>		4. DATE OF DEATH <b>July 18</b>		Month	Day	Year					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1904</b>		9. AGE (in years last birthday) <b>53</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Abraham E. Barnhart</b>				14. MOTHER'S MAIDEN NAME <b>Sue E. Frey</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-8897</b>		17. INFORMANT <b>Genevieve M. Barnhart</b>		Address <b>6008 Mannington Ave.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<b>CORONARY OCCLUSION</b>		<b>ARTERIO SCLEROSIS</b>		<b>O.B.R.SITY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>11510 Sprained ankle</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>1956 to 1957</b>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1010 NORTH Point Rd.</b>		20f. (City or town) (County) <b>Hampden Township</b> (State) <b>Pennsylvania</b>							
21. I certify that I attended the deceased from <b>Apr 4, 1956</b> to <b>Aug 18, 1957</b> , that I last saw the deceased alive on <b>July 11, 1957</b> and that death occurred at <b>4:25 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Morris A. Jacobs</b>										ADDRESS (Street, city or town, state) <b>1010 NORTH Point Rd.</b> DATE SIGNED <b>Morris A. Jacobs</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-22-1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland Co. Pennsylvania</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kassahn Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>JUL 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. A. L. Kassahn</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use as the burial-trust permit. Then please repeat, carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

RECEIVED  
BUREAU Y. C.  
JUL 22 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it at the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information or removal.

MEDICAL CERTIFICATION

Item 21 Film 219 817 18 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07117  
31

07143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	a. STATE	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b	Md Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Baltimore (7)		
3. NAME OF DECEASED (Type or print)	First	Middle	d. STREET ADDRESS	d. STREET ADDRESS		
Donald A. Bell			3611 Patterson Ave	3611 Patterson Ave	IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 29 yrs.	10. UNDER 1 YEAR Months Days Hours Min.	
Male	W		Nov 25 1927	29		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
Dentist	Dentist	Baltimore Md	USA			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
Verhey W. Bell	Myrtle Tschudy					
15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address			
925		Dr Arthur Bell	Pikesville Md			
B. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]	INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Inadvertent overdose of Alcohol & Barbiturates					
588.0	DUE TO					
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause lost.	(b)					
	DUE TO					
	(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
Anxiety State Severe (under Active therapy)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) None					19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. 4:00	Month Day Year 7/9/57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City, town) Baltimore	(County) Md	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) W.E. McGrath	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 7/9/57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/12/57	22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cem.	22d. LOCATION (City, town, or county) Pikesville, Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Pickens & Sons - Baltimore	ADDRESS	24a. REC'D BY REGISTRAR DATE 7/13/57	24b. REGISTRAR'S SIGNATURE Dr. John E. Martin			

REGELVÉ

UL 16 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07121

07147

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4	c. LENGTH OF STAY IN lb 35 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 W. Penn. Ave.	e. STREET ADDRESS 303 W. Penn. Ave.	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Bertha Reed	Middle Britton	4. DATE OF DEATH 7-10-57
5. SEX female	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-26-1869
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John H. Taylor	
14. MOTHER'S MAIDEN NAME Sarah E. Green		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Richard N. Britton, 303 W. Pa. Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  33IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10 days ?	
(b) DUE TO Hypertension		?	
(c) DUE TO arteriosclerosis		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 44IX		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1957, to July 10, 1957, that I last saw the deceased alive on July 9, 1957, and that death occurred at 11:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE GEORGE T. GILMORE, M.D.		ADDRESS (Street, city or town, state) LUTHERVILLE, MD DATE SIGNED 7/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-57	
22c. NAME OF CEMETERY OR CREMATORIUM Poplar Grove		22d. LOCATION (City, town, or county) Cockeysville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks Brooks Funeral Service		24a. ADDRESS 622 York Rd. Towson 4, Md.	
		24b. REC'D BY REGISTRAR July 11, 1957	
		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 12-12-2017 BY BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07118  
38

07144

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>2 weeks</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2900 Alden Road</i>		x. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>2900 Alden Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Jeanne Etche Belle</i>	Middle <i></i>	Last <i></i>
4. DATE OF DEATH	Month <i>July</i>	Year <i>1957</i>	Day <i>9</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 10-1922</i>
9. AGE (in years lost birthday) yrs. <i>34</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>New York - N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Albert Etche Belle</i>		14. MOTHER'S MAIDEN NAME <i>Helen Roosie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Lewis Belle - 2900 Alden Road</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral, Cardio-Vascular disease</i>   INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Thrombo - Phlebitis migrans</i>   6 yrs + (c) <i>Paralytic illness</i>   1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>October 19, 1950</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Baltimore, Md. Baltimore, Md.</i>	
21. I certify that I attended the deceased from <i>October 19, 1950</i> , to <i>July 9, 1957</i> , that I last saw the deceased alive on <i>July 8, 1957</i> , and that death occurred at <i>709 Taylor Ave.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>2810 Taylor Ave. Baltimore, Maryland.</i> DATE SIGNED <i>A.M. Bacon M.D. 7/9/57</i>			
ACTUAL SIGNATURE <i>A.M. Bacon</i>		PHYSICIAN'S NAME (Type) <i>A.M. Bacon</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 10, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Greenwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. W. Highfill</i>		ADDRESS <i>1330 Fulton St.</i>	
24a. REC'D BY REGISTRAR <i></i>		DATE <i>7/10/57</i>	
24b. REGISTRAR'S SIGNATURE <i>G. W. Highfill</i>			

BUREAU V. A.

JUL 11 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07119  
38

07145

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - City of Baltimore		c. LENGTH OF STAY IN lb 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6400 Bellona Avenue Mercy Villa Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
3. NAME OF DECEASED (Type or print) Mrs. Theresa O'Neill Bernard		First	Middle
		Last	4. DATE OF DEATH July 22 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH About 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 80 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Owen O'Neill		14. MOTHER'S MAIDEN NAME Ellen ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Roland O'Neill - 4329 Falls Road
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO Clerical Myocardial Disease July 25 1958  (c) DUE TO Arteritis, atherosclerosis 1.25			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  422.1 Arteritis, atherosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 25, 1955, to July 22, 1957, that I last saw the deceased alive on July 22, 1957, and that death occurred at 8:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Physician's Name (Type) M.D. 3013 N. Charles St. Baltimore, Maryland DATE SIGNED July 28, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/57	22c. NAME OF CEMETERY OR CREMATORIUM Greenmount
22d. LOCATION (City, town, or county) Baltimore		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Messelton - 805 N. Calvert St.		24a. REC'D BY REGISTRAR DATE 7/25/57	24b. REGISTRAR'S SIGNATURE Mabel Gray

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

1957 96

MEGELVÉD

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**07146 CERTIFICATE OF DEATH**

07120  
43

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Balto.	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Overlea	c. LENGTH OF STAY IN lb	a. STATE	Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		14 Glade Ave	x Overlea	b. COUNTY	Balto			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year			
5. SEX	F	6. COLOR OR RACE	W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
At Home		At Home		Balto		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
? Poltz		? Jeanette Bichell						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		None		Seannette Bichell 14 Glade Ave				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		10 days						
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Pneumonia...aspiration						
DUE TO								
(b) Cerebral Vascular Accident with Pharyngeal Paralysis		14 days						
DUE TO								
(c) Atherosclerosis Generalized Severe & Hypertension undetermined								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
441X 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from April 19 54 to July 17 19 57, that I last saw the deceased alive on 16 July 19 57, and that death occurred at 5:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) John C. Hyle MD		DATE SIGNED 17July57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19-57		22c. NAME OF CEMETERY OR CREMATORIUM Moreland Park Cem.		22d. LOCATION (City, town, or county) Taylor Ave Balto Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Doppel Bus		ADDRESS 710 Belair Rd.		24a. REC'D BY REGISTRAR DATE 19 1957		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Steffens		

WILHELM V. S.

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1916

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07122

07148

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>29yr2mth8dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Hedwig</b>	Middle Brucksch	4. DATE OF DEATH July 1 Month Day Year 19 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1873
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY <b>Germany</b>	
13. FATHER'S NAME <b>Roman Brucksch</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Pirene</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1954</b> , to <b>July 1, 1957</b> , that I last saw the deceased alive on <b>July 1, 1957</b> , and that death occurred at <b>3:40p M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stella Wachsler</i>	ADDRESS (Street, city or town, state) M.D. SPRING GROVE STATE HOSPITAL 7-2-57		
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-5-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Park Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE JUL 8 '57	24b. REGISTRAR'S SIGNATURE <i>John J. Cook</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the funeral director.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILSON V. S.  
MICHIGAN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07149

## CERTIFICATE OF DEATH

07123  
45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore 20 Md.	c. LENGTH OF STAY IN 1b 11 days.	d. STATE Delaware	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		People 209 Post 14	e. COUNTY Sussex	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moore St. Selbyville Del.	
3. NAME OF DECEASED (Type or print)		Ada P. Bentong	First	Middle	Last
4. SEX		Female	5. COLOR OR RACE	White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH		June 4 1880	8. AGE (In years from birthday)	77	9. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife	10b. KIND OF BUSINESS OR INDUSTRY	own home	11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY		U.S.A.			
13. FATHER'S NAME		Edw. Williams		14. MOTHER'S MAIDEN NAME	
15. WAS RELEASED EVER IN U. S. ARMED FORCES? (Yes, no, or withdrawn)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Mother Emanuel Bent 20 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Failure			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		8 days			
(b) DUE TO Cause (b), stating the under- lying cause last.		Antero-sclerotic heart disease 1 yr			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1957, to July 16, 1957, that I last saw the deceased alive on July 15, 1957, and that death occurred at 3:40 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		Joseph Miceli M.D. 108 S. Taylor Ave 7/16/57			
22d. BURIAL, CREMATION, REMOVAL (Specify)		22e. DATE THEREOF		22f. NAME OF CEMETERY OR CREMATORIUM	
Burial July 16, 1957		22g. ADDRESS		22h. LOCATION (City, town, or county) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24. REG'D BY REGISTRAR DATE		24i. REGISTRAR'S SIGNATURE	
John Shaler Selbyville Del.		July 18 1957		Edith Shirley	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-bronch permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

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BUREAU U. S.

JUL 4 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07150

## CERTIFICATE OF DEATH

07124

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FORESTVILLE</i>		c. LENGTH OF STAY IN Tb RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7500 MARLBORO DRIVE</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>	
3. NAME OF DECEASED (Type or print) <i>SR. M. FILIONA HELEN BURKE</i>		First <i>SR.</i>	Middle <i>FILIONA</i>
4. DATE OF DEATH <i>JULY 26, 1957.</i>		Last <i>HELEN</i>	Month Day Year
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 16, 1903</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TEACHER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>RELIGIOUS</i>	11. BIRTHPLACE (State or foreign country) <i>BOSTON, MASS.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>EDMOND BURKE</i>		14. MOTHER'S MAIDEN NAME <i>? MCREA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>SR. M. STAN. KOSKA</i>	
17. INFORMANT <i>SAME.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>416X</i> Conditions, if any, which gave rise to immediate cause (a), listing the under- lying cause last. (b) DUE TO <i>Coronary Thrombosis</i> (c) DUE TO <i>Rheumatic Cardiovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>400.1</i>			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour p. m.	Month 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1, 1957</i> to <i>July 1, 1957</i> , that I last saw the deceased alive on <i>July 1, 1957</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Vincent deP. Fitzpatrick, Jr.</i>			
PHYSICIAN'S NAME (Type) <i>Vincent deP. Fitzpatrick, Jr.</i>		ADDRESS (Street, city or town, state) <i>1120 St. Paul St.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>7-29-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>SISTERS' CEM.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles J. Dierdorff</i>		24a. ADDRESS <i>901 S. CONKLING ST.</i>	24b. REGISTRATION NUMBER <i>22-951957</i>
		24c. DATE <i>BALTO, MD.</i>	24d. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>

BUREAU V.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**07151 CERTIFICATE OF DEATH**

07125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>2yr1mth25dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3 yr ~ 1 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1924 Wilkens Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Beulah First Carmen Calder</b>		4. DATE OF DEATH <b>July 15 1957</b>		Month	Day	Year	
5. SEX female white		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>June 6, 1909</b>		9. AGE (In years last birthday) <b>48 yrs.</b> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Benjamin Parker</b>			14. MOTHER'S MAIDEN NAME <b>Lydia Hottle</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> INTERVAL BETWEEN ONSET AND DEATH							
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12, 1957</b> , to <b>July 15, 1957</b> , that I last saw the deceased alive on <b>July 15, 1957</b> , and that death occurred at <b>2:10PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <b>Stella Wachsler</b>		DATE SIGNED <b>7-15-57</b>					
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		CATONSVILLE P.8, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-18-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>JUL 18 '57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Alfred E. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFILE VFO

JUL 18 1957

BUREAU X-6

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07126

## 07152 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN Cockeysville

LENGTH OF STAY  
(in this place)

5 yrs.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED:  
(Type or Print)4. SEX:  
Female5. COLOR OR  
RACE: White6. 6. COLOR OR  
RACE: White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify): Widowed10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): Housewife10B. KIND OF BUSINESS  
OR INDUSTRY:

13. FATHER'S NAME:

Balthazar

Beyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

No.

16. SOCIAL SECURITY NO.

17. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4. IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY,

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

(A) DUE TO

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,

OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town)

INJURY OCCUR?

(County) (State)

21D. TIME (Month) (Day) (Year) (Hour)

OF INJURY

M.

at work

at work

92 (1980)

200

Appl.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07127

07153

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH		Rosewood State Training School a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE Maryland b. COUNTY Prince George's	
Owings Mills, Maryland		77 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Rosewood State Training School		d. STREET ADDRESS P.O. #1, Box 232	
3. NAME OF DECEASED (Type or print)		First Joyce	Middle Edna	Last Clements	4. DATE OF DEATH Month 7 Day 24 Year 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 7/19/56	9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Gerald Clements		14. MOTHER'S MAIDEN NAME Adelta Agnes Lint		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 202-00-0000		17. INFORMANT Address Parents and Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure due to heart malformation 754.0 DUE TO (Tetralogy of Fallot) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Mongoloid idiocy				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/15/56, 19, to 7/21/57, 19, that I last saw the deceased alive on 7/21/57, 19, and that death occurred at 5:30 PM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Harry G. Butler		M.D. Owings Mills, Maryland		7/25/57	
PHYSICIAN'S NAME (Type) Harry G. Butler		Rosewood State Training School			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-57		22c. NAME OF CEMETERY OR CREMATORIAL - May Cemetery	
22d. LOCATION (City, town, or county) Piscataway, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Will Chambers		ADDRESS 1406 Chopin St. NW		24d. REC'D BY REGISTRAR JUL 29 1957	
				24d. REGISTRAR'S SIGNATURE Mary Elmer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07154

## CERTIFICATE OF DEATH

07128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cotonesville</i>	c. LENGTH OF STAY IN 1b <i>House in Pines</i>	b. COUNTY <i>Baltimore</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Pines</i>		d. STREET ADDRESS <i>3915 Linney Load</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Abraham</i>	First <i>A</i>	Middle <i>b</i>	Last <i>Cohen</i>
4. DATE OF DEATH <i>7 25 1957</i>	Month <i>7</i>	Day <i>25</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>87</i>
9. AGE (In years (from birthday) yrs.) <i>87</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Army &amp; Navy</i>	11. BIRTHPLACE (State or foreign country) <i>Austria</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Rubin</i>	14. MOTHER'S MAIDEN NAME <i>Nachael</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>443X</i>	17. INFORMANT <i>Nathan M Cowan - Done</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 hr.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Hypertension Cardio-Vascular Disease</i>		DUE TO <i>10 yr. b)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>443X</i>		DUE TO <i>(c)</i>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>No</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6209 Frederick Ave.</i>	20f. (City or town) (County) <i>Baltimore</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>7-5</i> , 19 <i>57</i> , to <i>7-25</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7-25</i> , 19 <i>57</i> , and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6209 Frederick Ave.</i> DATE SIGNED <i>7-25-57</i>			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>	M.D.		
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>	Cotonesville-28, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>7-26-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Hebrew Young Men</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore</i> <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc 2100 Estate Place</i>	ADDRESS <i>2100 Estate Place</i>	24a. REC'D. BY REGISTRAR DATE <i>7-29-57</i>	24b. REGISTRAR'S SIGNATURE <i>Done</i>

BUREAU Y. S.

JUL 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. File pages 1 and 2 with the registrar or to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07129

Reg. Dist. No. 62

07155

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
b. CITY OR TOWN (If outside corporal's limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE Maryland		b. COUNTY Baltimore		
Eccleston		?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Eccleston		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Park Heights Ave.		
Park Heights Ave.		Park Heights Ave.		4. DATE OF DEATH		Month July	Day 1	Year 1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years less birthday) 37 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
Male W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 26, 1920				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Protestant Episcopal Clergy				Balto., Md.		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
William Caldwell Coleman		Elizabeth C. Brooke						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  yes		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
(If yes, give war or dates of service) WW II				Hon. Wm. C. Coleman, Same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death by strangulation due to hanging- DUETO suicide 6-7 hrs. (est.)								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Patient hung self on shower bar with his belt.						
20c. TIME OF INJURY Month, Day, Year Hours 8-9 o.m. est. 7/1/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Eccleston	(County) Balto., Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>D. D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 7-2-57
EXAMINER'S NAME (Type) D. D. Caples, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1957		22c. NAME OF CEMETERY OR CREMATORIUM St. Thomas		22d. LOCATION (City, town, or county) Garrison Forest, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Jenkins & Sons Co., 4905 York Rd.		ADDRESS		24a. REC'D BY REGISTRAR DATE 7/3/57		24b. REGISTRAR'S SIGNATURE Dorothy Russell		
VS. A15ME(5) SM 9/55								

WPA AWARD

EST 8

WPA AWARD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07130  
33

07156

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Baltimore MARYLAND		Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Maryland 12X-12	
Owings Mills		d. STREET ADDRESS Fox 249, R.F.D. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Navy	Middle Beatrice	Last Collins
4. DATE OF DEATH	Month 7	Day 30	Year 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/57
Female	Negro		9. AGE (in years (last birthday)) yrs 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel Boston Collins		14. MOTHER'S MAIDEN NAME Shirley Mary Ann Resnick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
752x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } DUE TO (b) Hydrocephalus, External, Cong. } DUE TO (c) Birth			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/29/57, 19, to 7/30/57, 19, that I last saw the deceased alive on 7/30/57, 19, and that death occurred at 10:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE: <i>Danny S. Butler</i> NAME (Type): <i>Danny S. Butler</i>		DATE SIGNED 7/31/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial August 1/1957		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM Clarken Chapel	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. D. Bailey, Parlington, Md.</i>		22d. LOCATION (City, town, or county) Harford County REGISTRAR'S SIGNATURE Mary Jones	
		24a. REC'D BY REGISTRAR DATE July 31, 1957 C. J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 page 3  
 To be detached for use as the Burial-Transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director.

BUREAU Y.

AUG 7 1962

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be rejoined by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with  
page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No.				
Item 9 1-15-57 et 07157 CERTIFICATE OF DEATH										07131 38				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>					c. LENGTH OF STAY IN 1b <b>4 Months</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Presbyterian Home of Maryland</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First <b>Dorothy E. Conrad</b>	Middle	Last	4. DATE OF DEATH <b>July 2</b>	Month	Day	Year						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>November 22, 1866</b>	9. AGE (in years last birthday) <b>90 1</b>	IF UNDER 1 YEAR Months <b>90</b>	IF UNDER 24 HRS. Days <b>1</b>	Hours <b>0</b>	Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME <b>August Miltz</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Presbyterian Home</b>		Address <b>Towson, Md.</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> <i>Cardio-Pulm. Vascular Disease &amp; advanced emphysema</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO <i>unknown</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerosis (and aging)</i> UNKNOWN DUE TO <i>unknown</i> (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pernicious Anemia</i>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Towson</b>		20f. (City or town) <b>Towson</b>		(County) <b>Md.</b>		(State) <b>Md.</b>				
21. I certify that I attended the deceased from <b>Jan 4</b> , 1957, to <b>July 1</b> , 1957, that I last saw the deceased alive on <b>June 29</b> , 1957, and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Towson</b> DATE SIGNED <b>7/2/57</b>														
ACTUAL SIGNATURE <b>Rollin C. Hudson</b> M.D.														
PHYSICIAN'S NAME (Type) <b>Rollin C. Hudson M.D.</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>London Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) <b>Md.</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>		24a. REG'D BY REGISTRAR <b>JUL 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Young</b>								

Y. V. MELIAU

1900

1900

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07132  
32

07158

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

Baltimore County

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mt. Wilson, Md.

c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Mt. Wilson State Hospital

3. NAME OF  
DECEASED  
(Type or print)First  
Severn

Middle

Warner Crockett

Last

4. DATE  
OF  
DEATH

Month

Day

Year

7

6

1957

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

12/2/94

9. AGE (In years  
last birthday)  
yrs.

62

10. IF UNDER 1 YEAR  
Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Cook

10b. KIND OF BUSINESS OR INDUSTRY

Waterman

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Henry S. Crockett

14. MOTHER'S MAIDEN NAME

Sadie Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Maggie N. Crockett (Wife) Addy Sal. Md.  
Hospital Records, Mt. Wilson State Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of Lung

INTERVAL BETWEEN  
ONSET AND DEATH

11 mo.

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19 20d. INJURY OCCURRED  
While Not while  
at work  at work   
20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)  
20f. (City or town)  
(County) (State)21. I certify that I attended the deceased from 5/6, 1957, to 7/6/57, 19, that I last saw the deceased  
alive on 7/6, 1957, and that death occurred at 6:15 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland July 6, 1957PHYSICIAN'S  
NAME (Type) William Newcomer, M.D., Superintendent22a. BURIAL, CREMATION,  
REMOVAL (Specify) Burial 22b. DATE THEREOF July 9, 1957 22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park 22d. LOCATION (City, town, or county) (State) Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR JULY 10 1957

24b. REGISTRAR'S SIGNATURE

HOLLOWAY &amp; COMPANY FUNERAL HOME ~ SALISBURY, MD.

DATE

Dorothy Newell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/54

BUREAU V. S.

UL 10 1957

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07133

07159

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Box 90, Dares Beach, Md.</b>		b. COUNTY <b>Calvert</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catoonsville 28</b>		c. LENGTH OF STAY IN lb <b>22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dares Beach</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spry Grove State Hospital</b>		d. STREET ADDRESS <b>Box 90 Dares Beach, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Jesse</b>		First <b>Jesse</b>	Middle <b>Mae</b>	Last <b>Dement</b>	4. DATE OF DEATH <b>July 13 1957</b>	Month <b>July</b>	Day <b>13</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-78</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Samuel B.</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Adams</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Bernard Dement</b>		Address <b>Box 90 Dares Beach, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>422.1</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>June 21, 1957</b> to <b>July 13, 1957</b> , that I last saw the deceased alive on <b>July 13, 1957</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Bruno Radauskas, Spry Grove St., Patoonsville, Md 7/13/57</b>		
ACTUAL SIGNATURE <i>Bruno Radauskas, M.D.</i>								DATE SIGNED <b>7/13/57</b>
PHYSICIAN'S NAME (Type) <b>Bruno Radauskas, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 7-16-57</b>		22b. DATE THEREOF <b>7-16-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedary Hill</b>		22d. LOCATION (City, town, or county) <b>Shilohland Md</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Mattingly</i>		ADDRESS <b>131-11</b>		24. REC'D BY REGISTRAR DATE <b>JUL 15 1957</b>		24b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. G.  
RECEIVED

1057

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07124

## CERTIFICATE OF DEATH

07134

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto. Co.</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>6yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6807 5th.Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
f. STREET ADDRESS <b>6807 5th.Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Felix</b>	First <b>Felix</b>	Middle <b></b>	Last <b>Dudzinski</b>
4. DATE OF DEATH <b>July 19 1889</b>	Month <b>July</b>	Day <b>12</b>	Year <b>1889</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 16, 1889</b>
9. AGE (In years last birthday) <b>67</b>	10. IF UNDER 1 YEAR yrs. <b>67</b>	11. IF UNDER 24 HRS. Months <b>6</b>	12. IF UNDER 24 HRS. Days <b>0</b>
13. FATHER'S NAME <b>Matthew Dudzinski</b>	14. MOTHER'S MAIDEN NAME <b>Josephine ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>180-01-4862</b>	17. INFORMANT <b>Bertha Dudzinski</b>	Address <b>6807 5th.Ave.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <b>atherosclerosis - especially coronary</b> 4 yrs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none none</b>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 12, 1957</b> to <b>July 12, 1957</b> , that I last saw the deceased alive on <b>July 12, 1957</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Maurice Feldman Jr.</b>	ADDRESS (Street, city or town, state) <b>Dr. Latrobe, Charles St., Baltz 2</b>		DATE SIGNED <b>7/13/57</b>
PHYSICIAN'S NAME (Type) <b>Maurice Feldman Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>7/15/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Rosary</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. S. Fialkowski</b>	ADDRESS <b>2007 Eastern Ave.</b>	24a. REC'D BY REGISTRAR DATE <b>15 1057</b>	24b. REGISTRAR'S SIGNATURE <b>J. Kelly</b>

BUREAU V. S

JUL

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 5 11 7-11-57 at

07135

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>20 days</b>		d. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hosp.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 21, D. C.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First	Middle	Last	4. DATE OF DEATH <b>DUEVER, SR.</b>	Month	Day	Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>7-10-1885</b>	9. AGE (In years lost birthday) yrs. <b>71/2</b>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <b>7</b>	Days <b>6</b>	Hours <b>19</b>	Min <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Duever</b>		14. MOTHER'S MAIDEN NAME <b>Mary Reiners</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>John Vasconcellos</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>		DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>		DUE TO <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain syndrome due to cerebral arteriosclerosis - depression</b>		DUE TO <b>(b)</b>		DUE TO <b>(c)</b>					
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>ADDRESS (Street, city or town, state)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour o. n. p. m.	Month <b>19</b>	Day <b>7-5</b>	Year <b>1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Spring Grove State Hospital</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>M.D.</b>	(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>7-5</b> , 19 <b>57</b> , to <b>7-6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-5</b> , 19 <b>57</b> , and that death occurred at <b>9 A.M.</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Baltimore, Maryland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Calvary on Mt.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Lee &amp; Son's Co.</b>		ADDRESS <b>300 W. 14th St., Baltimore, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 8 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Alt. Search</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**Page 3** should be detached for use as the burial-transit Permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the funeral director.

ΕΛΛΑΣ Η. Σ.

ΠΕΓΕΙΒΕ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07136

07161

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1 H		2. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		3. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>							
50 I		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>18 Hrs. 25 Min.</b>							
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>							
		d. STREET ADDRESS <b>32B Westway North</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>	Middle <b>E.</b>	Last <b>DUKES</b>	4. DATE OF DEATH <b>July</b>	Month <b>July</b>	Day <b>8</b>	Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 18, 1894</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months <b>62</b>	IF UNDER 24 HRS. Days <b>62</b>	Hours <b>62</b>	Min <b>62</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Air Craft Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Hoopers Island, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Franklin Dukes</b>		14. MOTHER'S MAIDEN NAME <b>Mary Phillips</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-05-8400</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION WITH MYOCARDIAL FOCAL NECROSIS</b> <b>EXX AND OLD INFARCTION</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO  (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m.      19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VA</b>		20f. (City or town) <b>6:15 PM</b>		(County)		(State)	
21. I certify that I attended the deceased from July 7, 1957, to July 8, 1957.											
ACTUAL SIGNATURE <i>Chien Wei Lan</i>				ADDRESS (Street, city or town, state) <b>M.D. VAH, FORT HOWARD, MARYLAND</b>						DATE SIGNED <b>7/9/57</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-12-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Bright, Inc. 6009 Harford Rd., Balt. 14, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>7/12/57</b>		24b. REGISTRAR'S SIGNATURE <b>De Damase Farber</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

MIL 15 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07162

## CERTIFICATE OF DEATH

Reg. Dist. No.

07137

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Baltimore MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Catoonsville 7 mo	
Catoonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Ridgeway Manor 119 S. Fremont Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
ESTELLA EMMA EDELER			LAST
4. DATE OF DEATH		Month	Day
July 31		Year	1957
5. SEX		6. COLOR OR RACE	
Female White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years from birthday) 74 yrs.	
July 12, 1883		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House wife at home		11. BIRTHPLACE (State or Foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John W. Miles		Eunice Goff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
None		17. INFORMANT	
Ruth E. Groves 119 S. Fremont Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral vascular accident (Probably hemorrhage)	
4. W.A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Hypertensive arteriosclerotic cardiovascular DUE TO disease	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1957 to July 31, 1957 that I last saw the deceased alive on July 31, 1957, and that death occurred at 10:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 8/1/57	
ACTUAL SIGNATURE George A. Knipp PHYSICIAN'S NAME (Type) George A. Knipp, M. D.		Baltimore 29, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 3 1957		22b. DATE THEREOF Aug 3 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Geipel 5311 Edmondson Ave		24a. REC'D BY REGISTRAR DATE AUG 2 1957	
		24b. REGISTRAR'S SIGNATURE Doris L. Geipel	

TO CAPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUENA V.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07138

Reg. Dist. No. 14

07163

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>168 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2915 S. Denham Circle</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>EARLE</b>	Middle N.	Last <b>EDWARDS</b>	4. DATE OF DEATH <b>July 22 1957</b>	Month <b>July</b>	Day <b>22</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 14, 1920</b>	9. AGE (In years (at birthday) yrs. <b>36</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Earle B. Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Gladys G. Gross</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes) no or unknown <b>Yes</b>		16. SOCIAL SECURITY NO <b>214-14-0798</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>PYELONEPHRITIS WITH PYONEPHROSIS, BILATERAL</b> DUE TO <b>CARCINOMA OF BLADDER</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>600.C</b>		(b) <b>METASTATIC LESION TO PELVIC FLOOR, PELVIC BONE</b> DUE TO <b>AND PROSTATE</b>				2 / YEARS	
(c) <b>CARCINOMA OF BLADDER</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Operation, 10/15/56, Bilateral Ureterosigmoidostomy</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>VA</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>VA</b>	Month <b>19</b>	Day <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VA</b>	20f. (City or town) <b>VA</b>	(County) <b>VA</b>	(State) <b>VA</b>
21. I certify that I attended the deceased from February 4, 1957, to July 22, 1957, <b>Chien Wei Lan</b> , and that death occurred at 5:22 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>VA Hospital, Ft. Howard, Maryland</b>		DATE SIGNED <b>7/23/57</b>	
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		M.D. <b>VA Hospital, Ft. Howard, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>		VA HOSPITAL, FT. HOWARD, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-26-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>		ADDRESS <b>Charles R. Law Mortuary, 802 Madison Ave., Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>7/25/57</b>	24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>		

BUREAU V. S.

JUL 29 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07164

## CERTIFICATE OF DEATH

Reg. Dist. No.

07139

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3yr5mth1ldys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>Annie</b>		4. DATE OF DEATH <b>July 25 1957</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 9, 1881</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Remous Ennie</b>		14. MOTHER'S MAIDEN NAME <b>Anne Sanders</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>450.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Catonsville 28, Maryland</b>		20f. (City or town) (County) <b>Spring Grove State Hospital</b> (State)	
21. I certify that I attended the deceased from <b>Feb. 11, 1954</b> , to <b>July 25, 1957</b> , that I last saw the deceased alive on <b>July 25, 1957</b> , and that death occurred at <b>9:55 a.m.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) M.D. <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7-25-57</b>	
22. BURIAL CREMATION, REMOVAL (Specify) <b>8-1-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>OLD ST PAULS O'DOWDELL SX. BALTO. MD.</b>	
22d. LOCATION (City, town or county) (State)		22e. REC'D BY REGISTRAR <b>JULY 2, 1957</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Inc. 1217 ST. PAUL SX</b>		24b. REGISTRAR'S SIGNATURE <b>Deb. Deuch</b>	

1  
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEAU V. S.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be filed with the funeral director.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07165

Item 2 Film 19-12-5, ex

07140

38

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		BALTO	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. STATE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		TOWSON	?	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MD		Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		TOWSON CONVALESCENT HOME		e. STREET ADDRESS		Hunt Club Lane		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LAURA	Middle B	Last FARSON	4. DATE OF DEATH	July	Month Year 26 1957	Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (State or foreign country)	July 8 1884	73 yrs.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
August OBruck heiser		Catherine Shallenberger							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CITIZEN OF WHAT COUNTRY?			
No		213-14-4669		Alma Eugene Kerman Same		U.S.A.			
Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1									
INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS									
INTERVAL BETWEEN ONSET AND DEATH YEARS(1)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
19									
21. I certify that I attended the deceased from FEB. 1954 to JULY 26, 1957, that I last saw the deceased alive on JULY 10, 1957, and that death occurred at 3A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE		ARTHUR KARFGREN M.D. 1532 HAYWOOD ROAD							
PHYSICIAN'S NAME (Type)		ARTHUR KARFGREN M.D. BALTIMORE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
Burial		7-29-57		Holy Redeemer		Balto Md			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS							
Henry J. Hendrix c/o ms 4905 York Rd		24a. REC'D BY REGISTRAR DATE 7/29/57							
		24b. REGISTRAR'S SIGNATURE Mabel Graye							

BUREAU V.

JUL 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07166

## CERTIFICATE OF DEATH

Reg. Dist. No.

07141  
28

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN 1b <b>x 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2806 Garnet Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2806 Garnet Road</b>	
3. NAME OF DECEASED (Type or print)	First <b>Mrs. Gertrude</b>	Middle <b>E. Callender Fischer</b>	Last 4. DATE OF DEATH <b>July 3rd</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin Evans</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Nickol</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mr. Herman P. Fischer, Jr. 2806 Garnet</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>none</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      Month      Day, Year p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-15-1957</b> to <b>7-2-1957</b> , that I last saw the deceased alive on <b>7-2-1957</b> , and that death occurred at <b>2A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8100 Harford Road, #14</b>	
ACTUAL SIGNATURE <b>Elliott Harris</b>		DATE SIGNED <b>7/3/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. S. Elliott Harris</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/6/57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>JULY 8 1957</b>	
ADDRESS <b>Leonard J. Ruck 5305 Harford Road #14</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. L. W. Jacobs</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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22-22-22-22

22-22-22

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date and hour on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07142  
47

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>	c. LENGTH OF STAY IN 1b	b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTO. YACHT CLUB</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. STREET ADDRESS <b>2030 ST. PAUL ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAYMOND EDGAR FISHER</b>	First	Middle	Last
4. DATE OF DEATH <b>JULY 3 1957</b>	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-18-08</b>
9. AGE (in years last birthday) <b>48</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEWSPAPER</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>UNKNOWN.</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE A. FISHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>2ND W. W.</b>	
17. INFORMANT <b>MYRTLE I. DEEDS 2540 GREENMOUNT</b>		Address <b>17UE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>FELL INTO WATER WHILE TRYING TO FREE A GROUNDED BOAT</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>902.4</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(County) (State)</b>
20f. (City or town) <b>(County) (State)</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>L E Baermann</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>8/8/57</b>
EXAMINER'S NAME (Type) <b>W E. BAERMANN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7/8/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>BALTO NATIONAL</b>	22d. LOCATION (City, town, or county) <b>FREDERICK RD. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Austin E. Donovan - 3818 Roland Ave.</b>		ADDRESS <b>Austin E. Donovan - 3818 Roland Ave.</b>	24a. REC'D BY REGISTRAR <b>JUL 5 1957</b>
			24b. REGISTRAR'S SIGNATURE <b>Edith J. ...</b>

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your records.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07143  
37

Reg. Dist. No.

07168

Item 12 Filled 7/20/57 cap

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holiday Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>Herman</b>		4. DATE OF DEATH July 18 1957	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>53</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poland</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Philip Fishkin</b>		14. MOTHER'S MAIDEN NAME <b>Mitze</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Benj. Chamish, 4403 Kennison Ave., Balto.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Angina Pectoris</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Hypertensive Arteriosclerotic C-V Disease</b> 6 mos.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D. D. Caples</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>7-19-57</b>
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-19-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt Carmel</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewellen 2100 Eutaw Place</b>	ADDRESS <b>Jack Lewellen 2100 Eutaw Place</b>	24a. REC'D BY REGISTRAR <b>JUL 22 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Dorothy Powell</b>

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1957

REGEV E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07144

07169

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>N. J.</b>		b. COUNTY <b>Abscon</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Atlantic City</b>		61X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Home - Regester Ave.</b>				d. STREET ADDRESS <b>Lennox Apts.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>ESTHER</b>	Middle	Last <b>FOX</b>	4. DATE OF DEATH <b>July 5, 1957</b>	Month <b>July</b>	Day <b>5</b>	Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 1872</b>		9. AGE (In years last birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Koopman</b>				14. MOTHER'S MAIDEN NAME <b>?</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Robert Fox - 2020 Hanover St.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> Condition, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c) DUE TO		<b>Circumonia (Bronchial)</b> <b>3 weeks</b>		<b>Generalized Arteriosclerosis 10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH			
19. MEDICAL CERTIFICATION <b>491X</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>May 16, 1957</b> to <b>July 4, 1957</b> , that I last saw the deceased alive on <b>July 4, 1957</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>2501 York Rd, Towson #4 Md.</b>		DATE SIGNED <b>7/7/57</b>	
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hebrew Friendship Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickner &amp; Sons - Baltimore</b>		ADDRESS <b>1118</b>		24a. REC'D BY REGISTRAR <b>July 8, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Gray</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. U. S.

SEASIDE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 17 7-16-57 et

07145

07170

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Overlea	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 Fuller Avenue		d. STREET ADDRESS 20 Fuller Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mr. John H. Funk	First	Middle	Last
4. DATE OF DEATH July 6th	Month	Day	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1898
9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Post Office		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William G. Funk		14. MOTHER'S MAIDEN NAME Sarah C. Hudgins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Anna J. Funk, 20 Fuller Ave. #6 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7-3 maz	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/9, 1951, to 7/1, 1957, that I last saw the deceased alive on 7/2, 1957, and that death occurred at 5A. M. from the causes and on the date stated above. ACTUAL SIGNATURE Robert W. Garis M.D. ADDRESS (Street, city or town, state) 1103 St. Paul Street DATE SIGNED 7/8/57			
PHYSICIAN'S NAME (Type) Dr. Robert W. Garis			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10/57	22c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Park	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE 10/10/57	24b. REGISTRAR'S SIGNATURE Mrs. A. L. Ryndesey

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SAVANNAH V. S.

1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07146

07171

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>45yr8mth7dys</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>FRANK</b>	Middle <b>L</b>	Last <b>FURNESS</b>	
4. DATE OF DEATH	Month <b>JULY</b>	Day <b>18</b>	Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-11-78</b>	
9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Alexander W. Furness</b> <i>Handwritten signature</i>		14. MOTHER'S MAIDEN NAME <b>Miria H. -</b> <i>Handwritten signature</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>158X</b> DUE TO <b>Retroperitoneal malignant tumor (Hodgkin's Disease?)</b>				
INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO				
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month. Day. Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>July 12</b> , 1957, to <b>July 18</b> , 1957, that I last saw the deceased alive on <b>July 18</b> , 1957, and that death occurred at <b>3:50</b> P.M., from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Stella Wachsler</i>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 7-18-57</b>		
DATE SIGNED				
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/22/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>All Saints Cem.</b>
22d. LOCATION (City, town, or county) (State) <b>Somerset Co. Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Dickner &amp; Sons. Inc.</i>		ADDRESS REC'D BY REGISTRAR DATE JUL 19 57		
		REGISTRAR'S SIGNATURE <i>Aut. Deemed</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFEVIEW

JUL 22 1957

URZAU V. A.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07147-

07133

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Relay</b>		d. STREET ADDRESS <b>5172 Viaduct Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5172 Viaduct Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MARTHA</b>	Middle <b>LILLIAN</b>	Last <b>GARLAND</b>	4. DATE OF DEATH	Month <b>July</b>	Day <b>14</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1882</b>	9. AGE (In years lost birthday) <b>75 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John L. Knode</b>				14. MOTHER'S MAIDEN NAME <b>Virginia C. Spielman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-05-3824</b>		17. INFORMANT <b>Mrs. Daisy Moszner-5172 Viaduce Ave., Relay, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 14, 1957</b> to <b>July 14, 1957</b> , that I last saw the deceased alive on <b>July 14, 1957</b> , and that death occurred at <b>8:00 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. H. Friedenreich</b> M.D. ADDRESS (Street, city or town, state) <b>1305 Francis St. 7/14/57</b> DATE SIGNED <b>7/14/57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Ticknor &amp; Sons - Baltim.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>7/18/1957</b>		24b. REGISTRAR'S SIGNATURE <b>Geo M. Tupper</b>	

RECEIVED  
BUREAU V. S.

JUL 18 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07148  
38

07172

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore City		c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodbrook Lane			d. STREET ADDRESS 119 Greenbrier Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Laura	Middle Augusta	Last German	4. DATE OF DEATH July 20 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH April 20, 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY City of Baltimore		11. BIRTHPLACE (State or foreign country) Towson, Maryland	
13. FATHER'S NAME Andrew Jackson German			14. MOTHER'S MAIDEN NAME Ann Rebecca Holland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Robert H. Wheeler - Woodbrook Lane	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma-wide-spread</u> INTERVAL BETWEEN ONSET AND DEATH More than DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Carcinoma of fundus uteri</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <u>Arteriosclerotic cardio-vascular disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>Feb. 5, 1957</u> , to <u>July 20, 1957</u> that I last saw the deceased alive on <u>July 20, 1957</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Towson, Maryland</u> DATE SIGNED <u>Charlotte McCarthy M.D.</u>					
ACTUAL SIGNATURE <u>Charlotte McCarthy</u>					
PHYSICIAN'S NAME (Type) <u>Dr. Charlotte McCarthy</u>		2919 St. Paul St. Balt. 18, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/23/57	22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill	22d. LOCATION (City, town, or county) (State) Towson, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Moore &amp; Son</u>		ADDRESS 805 N. Calvert St.	24a. REC'D BY REGISTRAR DATE JUL 23 1957	24b. REGISTRAR'S SIGNATURE <u>Charlotte McCarthy</u>	

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BUREAU V. S.

JUL 24 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07149

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN b <b>24 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>H.</b>	Last <b>GILLOTT</b>
4. DATE OF DEATH Month <b>JULY</b>	Day <b>22</b>	Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-86</b>
9. AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOLDIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>	11. BIRTHPLACE (State or foreign country) <b>CLEVELAND, OHIO</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John WILLIAM H. GILLOTT</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Norton</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>YES</b> 1-18-05 to 8-19-32	
16. SOCIAL SECURITY NO. <b>219-74-0601</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> 471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO DEATH <b>CHR. BRAIN SYNDROME ASSOCIATED WITH AMERIOSCLEROSIS, PUL. EMPHYSEMA, UNK.</b>		Duration UNKNOWN WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>471X</b>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, FORT HOWARD, MARYLAND</b>
20f. (City or town) <b>PIKEVILLE</b>		(County) <b>MARYLAND</b>	
		(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>June 28</b> , 1957, to <b>July 22</b> , 1957, and that death occurred at <b>8:22 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>PIKEVILLE, MARYLAND</b>	
ACTUAL SIGNATURE <b>Armen Bogosian</b>		DATE SIGNED <b>7-22-57</b>	
PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN</b>		M.D. VAH, FORT HOWARD, Maryland <b>7-22-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-25-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>DRUID RIDGE CEMETERY</b>	22d. LOCATION (City, town, or county) <b>PIKEVILLE</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>SEITZ FUNERAL HOME, 5209 YORK RD. BALTIMORE 12, MD.</b>		ADDRESS <b>7-23-57</b>	24a. REC'D BY REGISTRAR <b>Dawson L. Farley</b>
			24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use in the burial/transit permit. Then please remove carbon paper. Page 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 24 1957

BUREAU N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07150 41

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1721 Pinewood Drive</b>		d. STREET ADDRESS <b>1721 Pinewood Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>HERBERT WESLEY GOODWIN, SR.</b>		First	Middle	Last	4. DATE OF DEATH <b>July 31 1957</b>	Month	Day	Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 59 yrs.</b>	9. AGE (in years last birthday) <b>59 yrs.</b>	10. IF UNDER 1 YEAR <b>Months Days</b>	11. IF UNDER 24 HRS. <b>Hours Min.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grain</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		
13. FATHER'S NAME <b>Edward Herbert Wesley Goodwin</b>		14. MOTHER'S MAIDEN NAME <b>Sara Jones</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-05-8840</b> 17. INFORMANT <b>Alice G. Howard 1721 Pinewood Dr.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>		DUE TO <b>(c)</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Jack Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-1-57</b>		
EXAMINER'S NAME (Type) <b>Jack C. Collins</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Brooks Bradley</b>		ADDRESS <b>Dundalk 22, Md.</b>	24a. REC'D BY REGISTRAR <b>C. 5</b>	24b. REGISTRAR'S SIGNATURE <b>M. M. Kelly</b>				

URLEAU V. S.

MIG 5 1957

REGULATIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07151

07174

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY —							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Rutherville				Baltimore							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor				d. STREET ADDRESS 4310 St Paul St							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MARY B GRAHAM		First	Middle	Last	4. DATE OF DEATH July 31 Day Year 1957						
5. SEX F		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 23, 1870		9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		10c. BIRTHPLACE (State or foreign country) Horrstown Pa		10d. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Harry Walker		(father)		14. MOTHER'S MAIDEN NAME Clara Aver		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. R Walter Graham 3702 Greenway		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Branches pneumonia		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7-14 days					
50.0 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		DUE TO		(c) Generalized arteriosclerosis		yes					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491x Adenoma thyroid						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 11-25, 1956 to present, 19, that I last saw the deceased alive on 7/26/57, 19, and that death occurred at 4 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Ernest C Brown PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 1101 N Calvert St - 2		DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 2 1957		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore Md					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 2 '57		24b. REGISTRAR'S SIGNATURE All Search					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the funeral director.

URBAU V. 2

Aug 2 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

07152

07175

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>50 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		d. STREET ADDRESS <b>526 GAY STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>C</b>	Last <b>GREENAGE, JR.</b>	4. DATE OF DEATH <b>JULY 25, 1957</b>	Month <b>JULY</b>	Day <b>6</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JULY 25, 1922</b>	9. AGE (in years lost birthday) <b>34 yrs.</b>	10. IF UNDER 1 YEAR Months <b>3</b>	11. IF UNDER 24 HRS Days <b>1</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>		11. BIRTHPLACE (State or foreign country) <b>DENTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM C. GREENAGE, SR.</b>		14. MOTHER'S MAIDEN NAME <b>CORNELIA WHEELER</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>WW-11 213-18-5751</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA LEFT MAXILLARY SINUS WITH INDEX GENERALIZED BONE METASTASIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY EDEMA</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <b>VAH</b> attended the deceased from <b>May 16, 1957</b> , to <b>July 6, 1957</b> , and death occurred at <b>1:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHIEN WEI LIAN</b> M.D. <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>7-6-57</b>							
ACTUAL SIGNATURE <b>CHIEN WEI LIAN</b>							
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LIAN</b>		M.D.		VAH, FORT HOWARD, MARYLAND		7-6-57	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-9-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>SPRING GROVE CEMETORY</b>		22d. LOCATION (City, town or county) <b>DENTON, MARYLAND</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHARLES R. LAW MORTUARY, 802-01 MADISON AVE.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>July 9, 57</b>	24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>

RECEIVED  
JUL 11 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07153

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>1 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>105 Montrose Ave.</b>		d. STREET ADDRESS <b>105 Montrose Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>CATHERINE</b>	Middle	Last <b>GRILL</b>	4. DATE OF DEATH <b>July 18 1957</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1869</b>	9. AGE (In years lost birthday) <b>87 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Keiser</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Keebler</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ruth M. Disney - Dogwood Rd., Woodlawn</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ch. Myocardial Dicompensation</b> DUE TO <b>42201</b> Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1205.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4500</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 21, 1957, to July 18, 1957</b> , that I last saw the deceased alive on <b>July 16, 1957</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Witmer K. Gallagher</b> M.D.						ADDRESS (Street, city or town, state) <b>6209 Frederick Ave., Catonsville, Md.</b> DATE SIGNED <b>7-20-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/22/1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olive Cemetery</b>		22d. LOCATION (City, town, or county) <b>Randallstown</b> (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		ADDRESS <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>		24a. REC'D BY REGISTRAR <b>Jul 23 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Albrecht</b>	

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BUREAU V. S.

JUL 22 19

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07154 45

Reg. Dist. No.

07177

1. PLACE OF DEATH a. COUNTY	BALTIMORE	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	MD.	b. COUNTY	BALTO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	MIDDLE-RIVER	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	MIDDLE - RIVER		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Loyola	d. STREET ADDRESS	Box 524	BAY DRIVE		

3. NAME OF DECEASED (Type or print)	John M. GUNSAULUS	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX	M	6. COLOR OR RACE	W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
				<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	6-21-1911	96 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	MECHANIC	10b. KIND OF BUSINESS OR INDUSTRY	GLEN-MARTIN	11. BIRTHPLACE (State or foreign country)	Pa.	12. CITIZEN OF WHAT COUNTRY?	U.S.A.
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13. FATHER'S NAME	JAMES GUNSAULUS	14. MOTHER'S MAIDEN NAME	PEARL KINE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	LORNA GUNSAULUS	Address	SAME

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH
420.1	DUE TO	(b)		—
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO	(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED?
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>
--

ACTUAL SIGNATURE <i>M.B. Davis</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>7/28/57</i>
EXAMINER'S NAME (Type) <i>M.B. Davis MD</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	7-29-57	Bethesda Memorial Gardens	Bethesda, MD
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
<i>John J. Connally - Essap Biol</i>		13067	<i>Edith Buckley</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V.

JUL 31 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07155

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute same by certifying, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar. Prior to burial, cremation, or removal.

PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>11 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24</b>		d. STREET ADDRESS <b>1307 Elmina Way</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>First: Glenn Middle: Edward Last: Haines</b>		4. DATE OF DEATH <b>6-23-08</b>		5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-23-08</b>		9. AGE (In years from birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
				<b>Washington DC</b>		<b>USA</b>											
13. FATHER'S NAME <b>Edward Haines</b>		14. MOTHER'S MAIDEN NAME <b>Martha E. Williamson</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records Spring Grove State Hosp.</b>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Laceration Brain temporal lobe</i> 25222 DUE TO <i>lift contre coup</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) <i>Epileptic Seizure</i> DUE TO (c)</b>				Address <b>725-1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>											
19. WAS AN AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Convulsive Seizure</b>															
20c. TIME OF INJURY Hour <b>6</b> a.m. Month, Day, Year <b>6/25/57</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Catonsville 28 md</b>											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>J. W. Mc Grath</b>		EXAMINER'S NAME (Type) <b>W. E. Mc Grath</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/6/57</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7-12-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>SPRING GROVE STATE HOSP.</b>		22d. LOCATION (City, town, or county) <b>Catonsville 28, Maryland</b>											
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Smith</b>		ADDRESS <b>1557</b>		24a. REC'D BY REGISTRAR <b>1557</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>											

SUPERAU V. A.

1957



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07156

07179

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3 V O 1 . 4 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>201 S. Beechfield Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print)	First <b>Eva</b>	Middle <b>Blanche</b>	Last <b>Harman</b>	4. DATE OF DEATH	Month <b>July</b>	Day <b>17</b>	Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1881</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Joseph Tracy</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Jackson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> f d d . 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b> INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>493 X</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>July 9, 19 57</b> to <b>July 17, 19 57</b> , that I last saw the deceased alive on <b>July 17, 19 57</b> , and that death occurred at <b>8:40p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Stella Wachsler</i>	M.D. SPRING GROVE STATE HOSPITAL 7-18-57							
PHYSICIAN'S NAME (Type)		<b>Stella Wachsler, M. D.</b> Catonsville 28, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/20/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) <b>Woodlawn, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Schner &amp; Sons Mr Pa Ries</i>		ADDRESS <b>Route 17 Md.</b>		24a. REC'D BY REGISTRAR DATE <b>July 20 57</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Schner</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

July 2 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07157			
Item 1 Pg. 296-57										Reg. Dist. No. 41			
07126 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Dundalk				a. STATE		Md					
c. LENGTH OF STAY IN 1b		6 mos				b. COUNTY		Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2902 Dunmurry Road				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Dundalk					
3. NAME OF DECEASED (Type or print)		First May		Middle 26		Last Hart		4. DATE OF DEATH		Month July	Day 29	Year 1957	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
Female White		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		April 2 1885 72							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
at home				West Virginia									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Samuel Guesman		Minnie Gumpston											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No				Mrs Marie Knotts 2902 Dunmurry									
18. CAUSE OF DEATH [Enter only one cause of death for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		7-8-C-Cardio Vasculor Disease						7/29/57					
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)		DUE TO (c)		H.W.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED		Enter nature of injury in Part I or Part II of item 18.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour 6 A.M. P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)		20f. (City or town)		(County)		(State)			
July 29, 1957				Dundalk		Dundalk							
21. I certify that I attended the deceased from <u>July 29, 1957</u> to <u>July 29, 1957</u> that I last saw the deceased alive on <u>July 29, 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.													
ACTUAL SIGNATURE								ADDRESS (Street, city or town, state)					
PHYSICIAN'S NAME (Type)								DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county)		(State)					
Removal July 30/57		Reedsdale Cem		Reedsdale		West Va							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
J. B. Davis M.D.		Dundalk		1/30/57		John Kelly							
V5 A15 (4) 15M 9/55													

RECEIVED  
BUREAU V.

JUL 31 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07158

07180

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u>			b. COUNTY <u>Baltimore</u>		
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>512 Park Ave.</u>			d. STREET ADDRESS <u>512 Park Ave.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <u>Bertha</u>	Middle <u>Cain</u>	Last <u>H Hartley</u>	4. DATE OF DEATH Month <u>7-22</u>
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-1874</u>	9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>practical nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>hospital</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Cain</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth</u> <u>Stocksdale</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>M.Bremer Shearman, Sr., 512 Park Ave., Towson 4, Md</u>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			Coronary occlusion Arterio-sclerosis INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 years.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>420.0</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>36</u> to <u>22 July</u> , 19 <u>57</u> that I last saw the deceased alive on <u>22 July</u> , 19 <u>57</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Charles H. Reier</u> M.D. ADDRESS (Street, city or town) <u>6201 York Rd, Baltow, Md</u> DATE SIGNED <u>23 July 1957</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Friends Burial Grounds</u>	
22d. LOCATION (City, town, or county) <u>2506 Harford Rd., Baltow., Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u> Brooks Funeral Service 622 York Rd., Towson 4, Md.			ADDRESS <u>July 23, 1957</u>		24a. REC'D BY REGISTRAR <u>Mabel C. Gray</u>
					24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

GUEREAU Y.

JUL 25 1957

REGGIE FED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07181

## CERTIFICATE OF DEATH

07159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b lyrlmth5dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Henry	4. DATE OF DEATH July 7 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1866
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Issac Henderson		14. MOTHER'S MAIDEN NAME Sarah Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH unknown	
442.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 11, 1956, to July 7, 1957, that I last saw the deceased alive on July 6, 1957, and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) JOHN VASCONCELLOS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Nanjemoy Baptist
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. LOCATION (City, town, or county) Nanjemoy, Md.	24b. REGISTRAR'S SIGNATURE Allie Heath
VS A15 (4) 15M 9/55		ADDRESS	24a. REC'D BY REGISTRAR DATE JULY 9 '57

BUREAU V. S.

JUL 9 1957

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, which will be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07182 CERTIFICATE OF DEATH										07160 44	
										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>					e. STREET ADDRESS <b>1500 CLIFTON AVE.</b>						
3. NAME OF DECEASED (Type or print)		First <b>CHARLES</b>	Middle <b>E</b>	Surname <b>HENSON</b>	4. DATE OF DEATH <b>JULY 19 1957</b>	Month <b>JULY</b>	Day <b>19</b>	Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 5, 1922</b>	9. AGE (In years lost birthday) <b>34 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>		11. IF UNDER 24 HRS Days <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RADIO REPAIRMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RADIO REPAIR SHOP</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>CHARLES HENSON</b>										14. MOTHER'S MAIDEN NAME <b>LOUISE BROWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO. <b>217-16-1236</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>CIRRHOSIS OF THE LIVER</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5½ YEARS UNKNOWN</b>	
DUE TO (b) <b>PULMONARY TUBERCULOSIS</b>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>2228</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH FT. HOWARD, MD</b>		20f. (City or town) <b>VAH FT. HOWARD, MD</b>		(County) <b>MD</b>	(State) <b>MD</b>		
21. I certify that I attended the deceased from <b>JULY 18 1957</b> to <b>JULY 19 1957</b> and that death occurred at <b>10:25 AM</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>VAH FT. HOWARD, MD</b>	DATE SIGNED <b>7/19/57</b>
ACTUAL SIGNATURE <i>Chien Wei Lan</i>											
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-22-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) <b>5501 Frederick Ave. Balto. Md</b>		(State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Lan Mortuary</i>											
ADDRESS <b>802-04 Madison Ave Balto. 1, Md</b>											
24a. REC'D BY REGISTRAR <b>L 63 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>									

BUREAU V. S.

NO. 99 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 37183 2167-21-27 et

07183

## CERTIFICATE OF DEATH

07162

Reg. Dist. No. 38

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be reigned by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN lb <b>53 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>23 Aigburth Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
f. STREET ADDRESS <b>23 Aigburth Road</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH FORBES SHAW HERGENRATHER</b>		First <b>ELIZABETH</b>	Middle <b>FORBES</b>
Last <b>SHAW HERGENRATHER</b>		4. DATE OF DEATH <b>July 4,</b>	Month <b>July</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph Ford Shaw</b>	
14. MOTHER'S MAIDEN NAME <b>Jane Elizabeth Forbes</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF ORIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
19.9.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>ANEMIA. Secondary</b>		1/ year.	
DUE TO <b>MALIGNANCY. undetermined site</b>		1/ year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>420 ARTERIOSCLEROTIC HEART DISEASE.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>ONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>NOV 150</b> p.m.		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not white at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1956</b> , to <b>July 4, 1957</b> , that I last saw the deceased alive on <b>July 3, 1957</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>6310 York Rd Baltimore, Md.</b>	
ACTUAL SIGNATURE <b>A.S. Chalfant</b>		DATE SIGNED <b>July 5, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A.S. CHALFANT</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 6, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Chesterfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Centreville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons</b>		ADDRESS <b>Towson, Maryland</b>	
24a. REC'D BY REGISTRAR <b>July 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07184

## CERTIFICATE OF DEATH

07163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2132 Rockwell Ave.		d. STREET ADDRESS 2132 Rockwell Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REBECCA Middle M. Last HOENES		4. DATE OF DEATH Month July Day 1, Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1892
9. AGE (in years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
10c. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Tory		14. MOTHER'S MAIDEN NAME Clara -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no		16. SOCIAL SECURITY NO. <input type="checkbox"/> no	
17. INFORMANT Mrs. D. A. Nolker-3215 B Terrace Drive, Wash.		Address D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition due to excision of greater portion <i>5702</i> DUE TO of small intestine because of thrombosis of the Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO superior mesenteric artery. (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic vascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) 477.1	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 1957, to July 1, 1957, that I last saw the deceased alive on July 1, 1957, and that death occurred at 7:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>George A. Knipp</i> M.D. 4116 Edmondson Avenue DATE SIGNED July 3, 1957 PHYSICIAN'S NAME (Type) George A. Knipp, M. D. Baltimore 29, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/57	
22c. NAME OF CEMETERY OR CREMATORIUM Western Cemetery		22d. LOCATION (City, town, or county) Balto., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Nickner &amp; Sons - Baetz</i>		24a. REC'D BY REGISTRAR DATE JUL 9 '57	
ADDRESS <i>1101 Rockwell Ave.</i>		24b. REGISTRAR'S SIGNATURE <i>Alv. Leacock</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 5 1957

RECEIVED

07185

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL or and give nearest town)

TOWN Rural: Towson

LENGTH OF STAY  
(in this place)

1 month

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Eudowood Sanatorium

Towson 4, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

Phoenix, Md.

TOWN

STREET

ADDRESS

(If rural give location)

Paper Mill Rd.

3. NAME OF  
DECEASED:  
(Type or Print)

(First) John Martin

(Middle)

(Last) Hoffman

4. DATE  
OF  
DEATH:

7 2 1957

## 5. SEX:

Male

Female

white

black

6. COLOR OR  
RACE:

White

Black

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

Married

Single

## 8. DATE OF BIRTH:

8-31-1883

73 years

## 9. AGE last birthday:

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired):

Welder

10b. KIND OF BUSINESS OR  
INDUSTRY:

Eduvary

## 11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Chris Hoffman

## 14. MOTHER'S MAIDEN NAME:

Annie Ledley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

No

## 16. SOCIAL SECURITY NO.:

216-17-4581

## 17. INFORMANT &amp; ADDRESS:

Personal History  
Hospital Records, Eudowood Sanatorium

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X  
Immediate cause

(a) DUE TO

Pulmonary Tuberculosis

Interval Between  
Onset And Death  
6 mos.

## Antecedent causes (s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b) DUE TO

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURY

INJURY OCCURRED

While at

Not While

m. Work  At Work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-30 1957, to July 2, 1957, that I last saw the deceased  
alive on July 2, 1957, and that death occurred at 9:25 PM from the causes and on the date stated above.SIGNATURE  
(Degree or title)

ADDRESS

DATE SIGNED

Milton B. Kress M.D. Eudowood Sanatorium - Towson 4, Maryland

23. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (Specify)

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL  
REGISTRAR

DATE

RECD

BY

LOCAL REGISTRAR

REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

NAME

ADDRESS

July 3, 1957 Mabel C. Gray Brooks Funeral Service, Towson 4, Maryland

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 9 1977

REGELVET

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07165  
41

07127 Items 5&amp;6 Film 218 1/26/57 cap

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b>		c. LENGTH OF STAY IN lb <b>3</b> DUNDALK 22	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8213 BEAR CREEK DR.</b>		e. STREET ADDRESS <b>8213 BEAR CREEK DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>DANIEL WASHINGTON</b>		First <b>H</b>	Middle <b>U</b>
		Last <b>HUFHAM</b>	4. DATE OF DEATH <b>7-18-</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>		9. DATE OF BIRTH <b>JULY 22, 1895</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE MFG.</b>		9. AGE (In years to birthday) <b>67 yrs.</b>	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
		Hours <b>0</b>	Min. <b>0</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>NOAH HUFHAM</b>	
		14. MOTHER'S MAIDEN NAME <b>UNK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>31-05-44 MR. V. F. HUFHAM -</b>	
		17. INFORMANT <b>SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address <b>18mos</b>	
<b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)		<b>Ca of LUNG - RT</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>W.M.D.</b>	
20c. TIME OF INJURY Hour <b>a. m.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>BALTO.</b> (County) <b>COUNTY</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B. Davis M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis M.D.</b>		DATE SIGNED <b>7/19/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/22/56</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>CATH. L'AN'D'</b>		22d. LOCATION (City, town, or county) <b>BALTO. CO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Murphy, Dundalk Mort.</b>		24a. REC'D BY REGISTRAR <b>JUL 22 1957</b>	
ADDRESS <b>John J. Murphy, Dundalk Mort.</b>		24b. REGISTRAR'S SIGNATURE <b>John Kelly</b>	

TO DELIVER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
BUREAU K.S.

JUL 22 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07186

## CERTIFICATE OF DEATH

07166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Baltimore</i>		a. STATE <i>Maryland</i> b. COUNTY <i>2nd</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Catonsville</i>	<i>20 yrs</i>	<i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Paradise Nursing Home</i>		<i>105 Fairfield Drive</i>	
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>VIRGINIA</i>	Last <i>HUNDLEY</i>
4. DATE OF DEATH	Month <i>July</i>	Day <i>14</i>	Year <i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>FEMALE</i>	<i>WHITE</i>	<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>MAR-9-1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>None</i>		—	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>VIRGINIA</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>BEN FISHER</i>		<i>THEODOCIA RICE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or <i>unknown</i> )		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>Gangrene Lower Extremity left.</i>	
(b)		<i>Arterio sclerosis obliterans.</i>	
DUE TO  (c)		<i>Degenerative Heart Disease.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>Generalized Arterio sclerosis</i>		28	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>2nd</i> (County) <i>2nd</i> (State) <i>MD</i>	
21. I certify that I attended the deceased from <i>July 12</i> , 19 <i>57</i> , to <i>July 14</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>July 12</i> , 19 <i>57</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1303 Frederick Rd Catonsville 2nd</i> DATE SIGNED <i>7/14/57</i>	
ACTUAL SIGNATURE <i>W.E. Mc Greth</i>		M.D. <i>W.E. Mc Greth</i>	
PHYSICIAN'S NAME (Type) <i>W.E. Mc Greth</i>			
22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 17/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Coan Baptist Church, Heathsville</i>		22d. LOCATION (City, town, or county) <i>Heathsville Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Gandy 5311 Edmondson Ave</i>		24a. REG'D BY REGISTRAR <i>Jul 15 57</i> 24b. REGISTRAR'S SIGNATURE <i>Aut. Search</i>	
ADDRESS <i>John G. Gandy 5311 Edmondson Ave</i>		DATE <i>Jul 15 57</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

11-15 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0716738

07187

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO ATTEND**  **ATTENDIN**  **PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO be retained by the**  **funeral**  **or attending physician.**  
**TO FUNER**  **DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> ; b. COUNTY <u>Baltimore City</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb <u>19 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 34 <sup>th</sup> St., Charles & <u>Greenway Apts.</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard Enoch Pratt Hospital</u>		d. STREET ADDRESS <u>Greenway Apts., 34<sup>th</sup> St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <u>DR. Guy</u>	Middle <u>LE Roy</u>	Last <u>HUNNER</u>	4. DATE OF DEATH <u>7</u>	Month <u>July</u>	Day <u>14</u>	Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1868</u>	9. AGE (In years last birthday) <u>88</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. IF UNDER 24 HRS. Hours <u>0</u>	13. IF UNDER 24 HRS. Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OB-GYN Practice</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>John HUNNER</u>		14. MOTHER'S MAIDEN NAME <u>Eudora COOKE</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. G. L. HUNNER (wife)</u>		Address <u>Greenway Apts Baltimore</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Cardiac failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
(c) <u>Inf. Vena Cava thrombosis</u>						<u>1 month</u>		
DUE TO (c) <u>Metastatic Ca - liver</u>						<u>8 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>/</u>						
20c. TIME OF INJURY Hour a. m. p. m.	Month <u>July</u>	Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>/</u>	20f. (City or town) <u>/</u>	(County) <u>/</u>	(State) <u>/</u>	
21. I certify that I attended the deceased from <u>12-26, 1955</u> to <u>7-14</u> , 1957, that I last saw the deceased alive on <u>7-14</u> , 1957, and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 1216 John St; Baltimore, Md.</u>								
DATE SIGNED <u>Richard Fisch</u>								
ACTUAL SIGNATURE <u>Richard Fisch</u>		PHYSICIAN'S NAME (Type) <u>Richard Fisch</u>		DATE SIGNED <u>JUL 18 1957</u>				
22a. BURIAL, CREMATION, <u>Burial</u>	22b. DATE THEREOF <u>July 16, 1957</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>GreenMount</u>	22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>	ADDRESS <u>4905 York Road</u>	24a. RECD BY REGISTRAR <u>Mabel Grady</u>	24b. REGISTRAR'S SIGNATURE <u>Mabel Grady</u>					

RECEIVED  
BUREAU N.Y.

JUL 18 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07188

## CERTIFICATE OF DEATH

07168  
38

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Parkville

RURAL and give nearest town)

## c. LENGTH OF STAY IN lb

34 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

8910 Emla Ave.

## 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

## a. STATE

Maryland

## b. COUNTY

Baltimore

## c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Parkville

## d. STREET ADDRESS

8910 Emla Ave.

e. IS RESIDENCE  
ON A FARM?YES  NO 

## 3. NAME OF

(Type or print)

First Ernest

Middle

Last Jaeger

4. DATE  
OF  
DEATH

Month July

Year 1957

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

Nov. 24, 1885

9. AGE (In years  
from birthday)  
71 yrs

## 10. IF UNDER 1 YEAR

Months

## 11. IF UNDER 24 HRS.

Days

## 12. Day

Hours

## 13. Month

Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Floor Sender - Retired

## 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Ernest Jaeger

## 14. MOTHER'S MAIDEN NAME

Sophia Bast

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

214-36-8604 Carroll Jaeger

## 17. INFORMANT

Address

8910 Emla Ave.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

## DUE TO

Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH  
48 hours

11:30 A.M.

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

(b)

DUE TO

Atherosclerosis Coronary

?

(c)

Age

## MEDICAL CERTIFICATION

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour  
o. m. 19  
p. m.20d. INJURY OCCURRED  
While  
Not able  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County) (State)21. I certify that I attended the deceased from Jan 1, 1951, to July 12, 1957, that I last saw the deceased  
alive on July 11, 1957, and that death occurred at 2:39 P.M., from the causes and on the date stated above.  
ADDRESS (Street, city or town, state)ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

Frank T. Kasik, Jr.

9005 Harford Rd., Baltimore 14, Md.

DATE SIGNED  
7/13/5722a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

July 15, 1957

## 22c. NAME OF CEMETERY OR CREMATORI

Moreland Memorial

## 22d. LOCATION (City, town, or county)

(State)

Balto. Md.

## 23. FUNERAL DIRECTOR'S SIGNATURE

Lassahn Funeral Home

## ADDRESS

7401 Belair Rd.

## 24a. REC'D BY REGISTRAR

DATE JUL 15 1957

## 24b. REGISTRAR'S SIGNATURE

Dr. H. M. Bacchus

REFILE V. S.  
LCCN 1957

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**07189 CERTIFICATE OF DEATH**

07169  
38

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page **1** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page **3** to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages **1 & 2** should be filed with the registrar prior to burial, cremation, removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>XO</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home 301 Chesapeake Ave.</b>		d. STREET ADDRESS <b>1216 Murdock Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>LILLIAN</b>	Middle <b>MAY</b>	Last <b>JUNG</b>	4. DATE OF DEATH <b>July 9, 1957</b>	Month <b>July</b>	Doy <b>9,</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1881</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Keller</b>				14. MOTHER'S MAIDEN NAME <b>Susan -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Mrs. Lillian Batzer - 216 Murdock Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Hypertension Hypocompensative Cardio Vascula Disease</b> INTERVAL BETWEEN ONSET AND DEATH  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerosis</b> (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 5, 1955</b> , to <b>July 9, 1957</b> , that I last saw the deceased alive on <b>July 9, 1957</b> , and that death occurred at <b>4:10 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Laurence C. Post M.D.</b> ADDRESS (Street, city or town, state) <b>6805 York Rd Baltimore 12 Md</b> DATE SIGNED <b>4-11-57</b> PHYSICIAN'S NAME (Type) <b>Laurence C. Post</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/12/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Balto. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stein J. Lieberman &amp; Sons - Baltos Sub</b>				ADDRESS <b>7117 1/2</b>		24a. REC'D BY REGISTRAR DATE <b>7/11/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>							

RECEIVED  
UL 10 1973

CUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07190

07170

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. NAME OF DECEASED  
(Type or Print)

Charles E. Kellogg

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

Overleaf  
4516 Forestview Ave

c. LENGTH OF STAY IN BALTIMORE

Yrs.  
Mos.  
Days

5. SEX Male 6. COLOR OR RACE White 7. SINGLE MARRIED, WIDOWED, DIVORCED (Specify) Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY Glenn L Martin

13. FATHER'S NAME

Theodore Kellogg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

18. 420.1

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

(A)

DUE TO

acute myocardial infarction 1/2 hr.

(B)

DUE TO

(C)

chr. Coronary sclerosis

25 years

INTERVAL BETWEEN ONSET AND DEATH

## M.L. CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20. AUTOPSY?

YES  NO 21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK  NOT WHILE AT WORK 

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/1/1932 to 19 to 19, that (I) (we) last saw the deceased alive on Jan. 7, 1932, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles E. Kellogg

23B. ADDRESS

2320 Guttenplace

23C. DATE SIGNED

7/3/57

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.  M.D.24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

8/31/57

24C. NAME OF CEMETERY OR CREMATORI

Par'wood Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRY

AUG 1 1957

REGISTRAR'S SIGNATURE

R. J. Ruck, Keyserley

25. FUNERAL DIRECTOR

J. Ruck, 5305 Harford Rd

ADDRESS

BUREAU Y.

JUG 7 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07191

## CERTIFICATE OF DEATH

07171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmey</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(C) /</b>		b. COUNTY <b>Maryland</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>2915 Joppa Road</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First <b>Elizabeth Krause</b>	Middle	Last <b>July 31</b>	4. DATE OF DEATH <b>1957</b>	Month <b>July</b>	Day <b>31</b>	Year <b>19</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4 1867</b>		9. AGE (in years last birthday) <b>89</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. CITIZEN OF WHAT COUNTRY <b>Maryland</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>11. BIRTHPLACE (State or foreign country) Maryland</b>						
13. FATHER'S NAME <b>August Lovensen</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Seibert</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>17. INFORMANT</b>				Address <b>Dr Louis A M Krause 2619 Joppa Road</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardio vascular disease</b>										
DUE TO 420.1										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>with pneumonia</b>										
DUE TO										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.</b>										
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>								
21. I certify that I attended the deceased from <b>August 1951</b> to <b>July 31 1957</b> , that I last saw the deceased alive on <b>July 31 1951</b> , and that death occurred at <b>12:10PM</b> , from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) <b>1939 St. Paul Street Baltimore, Maryland</b>										
DATE SIGNED <b>8/1/57</b>										
MEDICAL CERTIFICATION										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										
22b. DATE THEREOF <b>Aug 3/57</b>										
22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cemetery</b>										
22d. LOCATION (City, town, or county) <b>Baltimore</b>										
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road</b>										
ADDRESS										
24a. REC'D BY REGISTRAR <b>8/5/57</b>										
24b. REGISTRAR'S SIGNATURE <b>Dr. L. M. Recan</b>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

AUG 25

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07172

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>504 Castle Drive</b>		d. STREET ADDRESS <b>504 Castle Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Clarence</b>	Middle <b>A.</b>	Last <b>Kriechbaum</b>
4. DATE OF DEATH	Month <b>July</b>	Day <b>3,</b>	Year <b>19 57</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1881</b>
9. AGE (in years last birthday) <b>76</b>	10. IF UNDER 1 YEAR Months <b>76</b>	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Casmir B. Kriechbaum</b>		14. MOTHER'S MAIDEN NAME <b>Lucy B. Evans</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Clara W. Kriechbaum 504 Castle Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Cancer of Sigmoid Colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<b>Cancer of colon.</b> ? 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 1, 1956</b> , to <b>July 3, 1957</b> , that I last saw the deceased alive on <b>July 1, 1957</b> , and that death occurred at <b>6:20 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>6702 Park Heights Ave.</b>	
ACTUAL SIGNATURE <b>Jonath Cohen</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>JONAS H. COHEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 6, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) <b>Pikesville</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>		24a. RECD BY REGISTRAR <b>John O. Mitchell</b>	24b. REGISTRAR'S SIGNATURE <b>O. O. Mitchell</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

JUL 8 1957

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. Alter this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

07173

**CERTIFICATE OF DEATH**

07193

Reg. Dist. No. ....

**1. PLACE OF DEATH**

COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	MARYLAND LENGTH OF STAY (In this place)
Baltimore	6 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Ridgeway Manor

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY Baltimore
TOWN	STREET ADDRESS (If rural, give location)
4702 Delaware Ave	

**3. NAME OF  
DECEASED  
(Type or Print)**(First) (Middle) (Last)  
Alexius Elder Kreis**4. DATE  
OF  
DEATH**

July 7, 1957

**5. SEX**

M. W.

**6. COLOR OR  
RACE**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)**8. DATE OF BIRTH**

Oct. 23, 1873

**9. AGE last birthday**

83

IF UNDER 1 YEAR:  
Month Days Hours Min.**10a. USUAL OCCUPATION** (Give kind of work  
done during most of working life, even  
retired)

Hotel Attendant American Oil Co.

**10b. KIND OF BUSINESS  
OR INDUSTRY****11. BIRTHPLACE** (State or foreign country)

Baltimore

**12. CITIZEN OF WHAT  
COUNTRY?**

U.S.A.

**13. FATHER'S NAME**

William Kreis

**14. MOTHER'S MAIDEN NAME**

Florilla Ann Shaw

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?**  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**

215-09-0081

**17. INFORMANT & ADDRESS**

Mrs. Adelma O'Mara 3727 7 Ave

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH****IMMEDIATE CAUSE**

(A)

**18. MEDICAL CERTIFICATION**

THROMBOSIS, CEREBRAL

**INTERVAL BETWEEN  
ONSET AND DEATH**

36 HRS.

**ANTECEDENT CAUSE(S) DUE TO****DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE****STATING UNDERLYING CAUSE LAST, DUE TO**

(B)

(C)

ARTERIOSCLEROSIS

GEN'L.

15 YRS.

**19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**YES  NO **21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)****21c. WHERE DID INJURY OCCUR? (City or town)**

(County)

(State)

**21d. TIME OF INJURY (Month) (Day) (Year) (Hour)****21e. INJURY OCCURRED****21f. HOW DID INJURY OCCUR?**M. at work  Not while 

22. I hereby certify that I attended the deceased from May 2, 1957, to July 7, 1957, that I last saw the deceased alive on July 7, 1957, and that death occurred at 5:25 AM, from the causes and on the date stated above.

**SIGNATURE**

ADDRESS (Street, city, town, state)

DATE SIGNED

**23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)**

Burial July 19, 1957 Western Cemetery M.D.

**LOCATION (City, town, or county)**

(State)

**24. RECORD BY REGISTRAR**

JUL 16 1957 Dev. Sproule

**REGISTRAR'S SIGNATURE****25. FUNERAL DIRECTOR'S SIGNATURE****ADDRESS****DATE**Loring Byers 5005 Phyltch St.  
Baltimore 15, Md.

BUREAU V. S

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07194

## CERTIFICATE OF DEATH

17174

38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>M.D.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Paraville</i>		c. LENGTH OF STAY IN lb	b. COUNTY <i>Baltimore</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3007 Woodside Ave</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. STREET ADDRESS <i>3007 Woodside Ave</i>									
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>J.</i>	Last <i>Kuhn</i>	4. DATE OF DEATH <i>July 29</i>	Month <i>July</i>	Day <i>29</i>	Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/27/96</i>	9. AGE (in years from birthday) <i>61</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Coverer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Joseph J. Kuhn</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Kern</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Louisa Kuhn, 3007 Woodside Ave</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Acute CORONARY Occlusion		INTERVAL BETWEEN ONSET AND DEATH <i>15 MINOS</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		HyperTensive-ARTERIOSCLEROTIC-C.T.D		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I attended the deceased from <i>April 29, 1948</i> , to <i>July 29, 1957</i> , that I last saw the deceased alive on <i>July 22, 1957</i> , and that death occurred at <i>645 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>3501 ST. Paul ST. Balt. - 18. Md.</i>		DATE SIGNED <i>7/31/57</i>					
ACTUAL SIGNATURE <i>Albert J. Himesfarb</i>		PHYSICIAN'S NAME (Type) <i>ALBERT J. HIMELFARB</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug. 2, 1957</i>		22b. DATE THEREOF <i>Aug. 2, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park</i>	22d. LOCATION (City, town, or county) <i>Balt. Ma.</i>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc. 5305 Harford Rd.</i>		ADDRESS <i>Leonard J. Ruck, Inc. 5305 Harford Rd.</i>		24a. REC'D BY REGISTRY DATE <i>31 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Dell M. Bacon</i>				

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUL 31 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Give pages 1 and 2 with the registration for a burial or removal.

VS. ATMS(E)S  
SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07175  
38

Item 20 Film 218 07195

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)	
<i>BALTIMORE Co.</i>		a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>2 yrs 3 mths</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ARMA COST NURSING HOME</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ADAM KUPIDLOWSKI</i>		First <i>A</i>	Middle <i>K</i>
4. DATE OF DEATH	Month <i>7</i>	Day <i>6</i>	Year <i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>18, 1911</i> <i>Sept Aug 1911</i>
<i>M</i>	<i>W</i>	<i>WIDOWED</i> <input type="checkbox"/>	9. AGE (In years) <i>45 yrs</i> <i>45 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salvage Corpsman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fire Ins. Sal</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wladyslaw Kupidlowski</i>		14. MOTHER'S M AIDEN NAME <i>Michalina Filipak</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>WWII</i>	
17. INFORMANT <i>John Kupidlowski</i>		Address <i>912 N. Strooper St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>960X</i> DUE TO <i>Cranial Cerebral Injury</i> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>Massive Gastro Intestinal Hemorrhage</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Salvage truck and Fire truck collision</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>4/18/57</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>street</i>		20f. (City or town) (County) (State) <i>Baltimore &amp; Caroline Sts. Baltimore</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Wladyslaw Kupidlowski</i>	DATE SIGNED <i>7-7-57</i>		
EXAMINER'S NAME (Type) <i>John A. Moran</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 10, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Holy Rosary Cemt.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i>	24a. REC'D BY REGISTRAR <i>1119</i>	24b. REGISTRAR'S SIGNATURE <i>Malvina Hayes</i>	DATE <i>1119 1957</i>

BUREAU V. S.

JUL 9 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07128

## CERTIFICATE OF DEATH

Reg. Dist. No. 17176/1

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>	c. LENGTH OF STAY IN 1b <i>1b</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>105 Ballimore Ave</i>		d. STREET ADDRESS <i>105 Ballimore Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i>	First <i>W</i>	Middle <i>Lairie</i>	Last <i>July</i>
4. DATE OF DEATH <i>July 7 1957</i>	Month <i>July</i>	Day <i>7</i>	Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 27 1880</i>
9. AGE (In years, to birthday) <i>77 yrs.</i>	10. UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS. <i>Days</i>	12. Hours <i>Min</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipyard Ret</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Beth</i>	
11. BIRTHPLACE (State or foreign country) <i>Scotland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Alexander Lairie</i>		14. MOTHER'S MAIDEN NAME <i>Jane Rodger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Marion Koenig 2837 Dunman Ct</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-17</i> , 19 <i>57</i> , to <i>7-4</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7-4</i> , 19 <i>57</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Eugene F Nevy</i> M.D. <i>7001 Morris St Tom Rd</i> PHYSICIAN'S NAME (Type) <i>Eugene F Nevy</i> DATE SIGNED <i>Dundalk 28, Md</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 6 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Oaklawn</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Co</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ulrich Funeral Home 2112 Dundalk</i>		24a. REC'D. BY REGISTRAR DATE <i>5 1957</i>	24b. REGISTRAR'S SIGNATURE <i>J. Kelly</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

URÉAU V. G.

JUL 8 1957

DEGEMINI

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07177

07196

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>		c. LENGTH OF STAY IN lb <b>3 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3611 Langrehr Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Minnie</b>	Middle <b>Lammers</b>	4. DATE OF DEATH <b>July 9, 1957.</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1869</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Schetlich</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Hentzel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Dr. Walter J. Lammers 417 Hollen Rd. (12)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>about 1 yr</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>June 1, 1957</b> to <b>July 9, 1957</b> that I last saw the deceased alive on <b>July 7, 1957</b> and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter S. Kibbitt</b>		ADDRESS (Street, city or town, state) <b>4508 N. Charles St.</b> DATE SIGNED <b>7/10/57</b>	
PHYSICIAN'S NAME (Type) <b>Walter S. Kibbitt</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-11-1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong 3207 W North Ave</b>		24a. REC'D BY REGISTRAR DATE <b>7/12/57</b>	
ADDRESS <b>3207 W North Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Wm. Martin</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

1951-10-19

DEPARTMENT OF STATE  
U.S. GOVERNMENT

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07178  
44

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>86 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TYASKIN</b>	
3. NAME OF DECEASED (Type or print) <b>LLOYD</b>		First <b>L.</b>	Middle <b>L.</b>
4. DATE OF DEATH <b>JULY 28 1957</b>	Month <b>JULY</b>	Day <b>28</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-95</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TYASKIN, MARYLAND</b>	
10c. BIRTHPLACE (State or foreign country) <b>TYASKIN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>H. LAMORE</b>		14. MOTHER'S MAIDEN NAME <b>GARNETTA DICKSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b> DUE TO <b>CIRRHOSIS OF LIVER</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>PYELONEPHRITIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>MAY 1 1957</b> to <b>JULY 28 1957</b> , and that death occurred at <b>9:10 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
ACTUAL SIGNATURE <i>Harold R. Johnson</i>		DATE SIGNED <b>7-28-57</b>	
22a. PHYSICIAN'S NAME (Type) <b>HAROLD R. JOHNSON</b>		22b. M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
22c. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22d. LOCATION (City, town, or county) <b>TYASKIN, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.G. MESSICK</b>		24a. ADDRESS <b>TYASKIN, MARYLAND</b>	
24b. REC'D BY REGISTRAR <b>30 1957</b>		24c. REGISTRAR'S SIGNATURE <i>Seawright</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
07198 CERTIFICATE OF DEATH

07179  
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>57 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d. STREET ADDRESS <b>3232 Blair Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>LEONARD</b>	4. DATE OF DEATH <b>JULY</b>	Month <b>13</b>	Day <b>19</b>	Year <b>57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1 1889</b>	9. AGE (In years lost birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Grinder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Elec. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Florence, Ala.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Thomas Leonard</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Cox</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>160-07-2388</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL EXSANGUINATION</b>								
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>157X</b>								
(b) <b>CA OF PANCREAS WITH METASTASES</b>				UNKNOWN				
DUE TO  (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Ca of Prostate</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	Year	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>May 17</b> , 1957, to <b>July 13</b> , 1957, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <b>W. Dudley</b> M.D. <b>Veterans Administration Hospital</b> 7/13/57								
PHYSICIAN'S NAME (Type) <b>W. DUDLEY, MD.</b> Fort Howard, Maryland.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-17-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>			22d. LOCATION (City, town, or county) <b>Baltimore, Maryland.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Bright Inc.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>7/18/57</b>		24b. REGISTRAR'S SIGNATURE <b>Leviason L. Farley</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, which should be detached for use as the burial permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5. A. 2

2-201

100-2578

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07180

07199

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton 4</b>		c. LENGTH OF STAY IN 1b <b>Ruxton 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bellona Avenue</b>		d. STREET ADDRESS <b>Bellona Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ANNA</b>	Middle <b>E.</b>	Last <b>LEWIS</b>
4. DATE OF DEATH	Month <b>July</b>	Year <b>1957</b>	Day <b>19</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1867</b>
9. AGE (in years last birthday) <b>89 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Single maiden</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Simon P. Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Keggris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT <b>Mrs. C. W. Amos, Bellona Ave., Ruxton 4, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4'. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c)		Address  <i>Heart failure</i> <i>generalized arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>many years</b>	
19. MEDICAL CERTIFICATION		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19		White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
21. I certify that I attended the deceased from _____		July 3, 1957 to July 7, 1957 that I last saw the deceased alive on _____	
ACTUAL SIGNATURE <i>Franklin E. Leslie</i>		ADDRESS (Street, city or town, state) <b>2929 N. Charles St - Bullock 18th</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 10, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Everett Cemetery</b>
22d. LOCATION (City, town, or county) <b>Everett, Penna.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns Sons</i>		24a. ADDRESS <b>Towson, Maryland</b>	24b. REC'D BY REGISTRAR <b>July 8, 1957</b>
		24b. REGISTRAR'S SIGNATURE <i>Mabel C. Gray</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

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REG-10-V-14

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07181  
7200

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1139 Roland Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBERT</b>		First <b>Alpheus</b>	Last <b>A.</b>	4. DATE OF DEATH <b>July 25</b>	Month <b>July</b>	Day <b>25</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/88</b>	9. AGE (In years lost birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months <b>68</b>	IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rubber Plant</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert</b> <b>John Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Ann</b> <b>Francis Miller</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-05-8098A</b>		17. INFORMANT <b>Clin/Rec. Vets. Admin. Hospital, Fort Howard, Md.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA TO BRAIN</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5272</b>		(b) <b>CARCINOMA OF LUNG RIGHT. POST OPERATIVE</b> DUE TO (c)				UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Pneumonectomy</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Winchester, Virginia</b>	(County) <b>Virginia</b>	(State) <b>Virginia</b>	
21. I certify that I attended the deceased from <b>July 12, 1957</b> , to <b>July 25, 1957</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>3 Lawrence Fleisher, M.D. Veterans Administration Hospital, 7/25/57</b>							
DATE SIGNED <b>7/25/57</b>							
ACTUAL SIGNATURE <b>3 Lawrence Fleisher, M.D. Veterans Administration Hospital, 7/25/57</b>							
PHYSICIAN'S NAME (Type) <b>T. LAWRENCE FLEISHER, M.D.</b> Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>7/27/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Hebron Cemetery</b>	22d. LOCATION (City, town, or county) <b>Winchester, Virginia</b>	(State) <b>Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Tickner &amp; Sons</b>	ADDRESS <b>Baltimore, MD 21217</b>	24a. REC'D BY REGISTRAR <b>1/1/59</b>	24b. REGISTRAR'S SIGNATURE <b>Lawrence L. Fleisher</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

JUL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07201

## CERTIFICATE OF DEATH

071825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c. LENGTH OF STAY IN 1b <i>35 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1642 Rickenbacker Rd.</i>		e. STREET ADDRESS <i>1642 Rickenbacker Rd.</i>		f. DATE OF DEATH <i>JULY 30 1957</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>W.</i>	Last <i>LingenFelder</i>	Month <i>JULY</i>	Day <i>30</i>	Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 30, 1873</i>	9. AGE (In years last birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney - Retired SELF-Employed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Henry F. LingenFelder</i>		14. MOTHER'S MAIDEN NAME <i>Virginia PARISS</i>		Address <i>1642 Rickenbacker Rd.</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>mrs. Laura LingenFelder</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arterio-sclerotic Cardio-Vascular Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH <i>days</i>		
19. MEDICAL CERTIFICATION		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.      While at work <input type="checkbox"/> at work <input type="checkbox"/> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from <i>July 29/57</i> , 1957, to <i>July 30/57</i> , 1957, that I last saw the deceased alive on <i>July 30</i> , 1957, and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James J. White</i> PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burying</i>		ADDRESS (Street, city or town, state) <i>422 Easton Ave., Baltimore 21, Md.</i>						DATE SIGNED
22b. DATE THEREOF <i>Aug. 2, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL PARK <i>Moreland Memorial Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore, md.</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lessons Funeral Home</i>		ADDRESS <i>7401 Belair Rd.</i>		24a. REC'D BY REGISTRAR <i>HUG 5</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Hanley</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be given to the funeral director.  
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

Aug 22 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07183

44

07202

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>39 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		19 X 0	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Route No. 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>WILLIS</b>	Middle <b></b>	Last <b>LONG, JR.</b>	4. DATE OF DEATH <b>July</b>	Month <b>2</b>	Day <b>19</b>	Year <b>57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>October 29, 1916</b>	9. AGE (In years at birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Pocomoke City, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Willis Long, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Edna Kirkwood</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1998</b>		ADENOCARCINOMA, JUNCTION OF ESOPHAGUS AND XNK CARDIAC OF STOMACH, WITH GENERALIZED METASTASES		INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day VA	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from May 21, 1957, to July 2, 1957.		ADDRESS (Street, city or town, state)					
and that death occurred at 4:20AM, from the causes and on the date stated above.		DATE SIGNED <b>7/2/57</b>					
ACTUAL SIGNATURE <i>Chien Wei Lan</i>	M.D. VA HOSPITAL, FORT HOWARD, MARYLAND						
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-7-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Tindley's Chapel Cemetery</b>		22d. LOCATION (City, town, or county) <b>Somerset County, Maryland</b>	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gaffer W. Winter</i>		ADDRESS <b>New Church, VA</b>		24. RECORD REGISTRATION <b>JUL 9 1957</b>	25. REGISTRAR'S SIGNATURE <i>Howard L. Fisher</i>		
Walter Savage Funeral Home, New Church, Virginia				DATE			

RECEIVED  
MAY 9 1957

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07184  
38

17203

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Baltimore</i> MARYLAND		<i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Towson</i>	<i>1b</i>	<i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>2721 Maple Ave</i>		<i>2721 Maple Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Margaret E</i>		<i>L</i>	<i>ord</i>
4. DATE OF DEATH	Month	Day	Year
<i>July 27</i>	<i>July</i>	<i>27</i>	<i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>F</i>	<i>W</i>	<i>Sept 14-1865</i>	<i>92</i>
9. AGE (In years from birthday) Months	10. IF UNDER 1 YEAR Days	11. IF UNDER 24 HRS Hours	12. IF UNDER 24 HRS Min
<i>92</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>At home</i>		<i>11. BIRTHPLACE (State or foreign country)</i>	
		<i>Baltimore Md</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Henry Nagel</i>		<i>Elizabeth Worthy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>#22.1</i> DUE TO		<i>ASCV disease, Endocarditis, cerebral embolism</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>X</i> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
		<i>Baltimore</i> (Baltimore) (Md)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>William Thomas Lloyd</i>		M.D.	
PHYSICIAN'S NAME (Type)		<i>William Thomas Lloyd</i>	
22a. BURIAL, CREMATION, RE-CREMATION (Specify)		22b. DATE THEREOF	
<i>BURIAL</i>		<i>7-30-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town or county) (State)	
<i>Parkwood</i>		<i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Leonard J. Ruck, Inc</i>		<i>1305 Hanford Rd</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<i>JUL 30 1957</i>		<i>Dr. M. Brown</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

JUL 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

67294

## CERTIFICATE OF DEATH

07185  
78

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home 301 West Chesapeake Avenue				e. STREET ADDRESS 1201 East North Avenue											
3. NAME OF DECEASED (Type or print)		First Nancy	Middle E.	Last Lotterer	4. DATE OF DEATH	Month July	Day 11	Year 19 57							
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 21, 1893	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore County				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Keyes				14. MOTHER'S MAIDEN NAME Nancy E. Hepbrun											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO						17. INFORMANT J. Edwin Scoggins, 1205 East North Avenue					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)				Carcinoma Colon & General Metastasis						INTERVAL BETWEEN ONSET AND DEATH 3 mos.					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day Nat while at work <input type="checkbox"/>	20d. INJURY OCCURRED White		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County)	(State)				
21. I certify that I attended the deceased from 29 Oct. 1954, to 11 July 1957, that I last saw the deceased alive on 11 July 1957, and that death occurred at 220 P.M. from the causes and on the date stated above.															
ACTUAL SIGNATURE Chas W Edmonds PHYSICIAN'S NAME (Type) Chas. Wm Edmonds															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-15-57		22c. NAME OF CEMETERY OR CREMATORIUM Western Cemetery		22d. LOCATION (City, town, or county) Baltimore				(State)					
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc. 1217 St. Paul Street						ADDRESS		24a. REC'D BY REGISTRAR DATE 11 15 1957		24b. REGISTRAR'S SIGNATURE Mabel Grey					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the funeral director. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PEGIVED

1957

BRIEFLY V. S.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**07205 CERTIFICATE OF DEATH**

Reg. Dist. No.

07186

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE							
Baltimore MARYLAND		Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY							
Catonsville	1mth25dys								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
SPRING GROVE STATE HOSPITAL	d. STREET ADDRESS								
3. NAME OF DECEASED (Type or print)		First	Middle						
Elfrieda		Umbach	Last						
4. DATE OF DEATH	Month	Day	Year						
JULY 2, 1957	1957	19	57						
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 8, 1885	71 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
housewife				Germany		U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Henry Umbach				Katherine Doering					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		unknown		Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure									
422.1 DUE TO Myocardial degeneration with hypertrophy									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)									
DUE TO Arteriosclerosis (c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
15. (b)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that I attended the deceased from May 3, 1957, to July 2, 1957, that I last saw the deceased alive on July 2, 1957, and that death occurred at 7:50 P.M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Louie Frances Woodward, M.D.</i>									
PHYSICIAN'S NAME (Type) Louie Frances Woodward, M. D.									
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL									
DATE SIGNED 7-2-57									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
<i>Ground</i>		July 5, 1957		London Park Cem.		Baltimore 29 N.W.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<i>Swab (T.B.)</i>		McDonald Ave		Date 7-8-57		C. J. Smith			

BUQUY V. 4

JUL 22 1957

PUBLIC LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07187

07206

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MD.</b>		c. LENGTH OF STAY IN 1b <b>1 Hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1142 W. PRATT STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>AMOS</b>	Middle <b>R.</b>	Last <b>MACE</b>	4. DATE OF DEATH	Month <b>July</b>	Day <b>10</b>	Year <b>1957</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 23, 1923</b>	9. AGE (in years (last birthday) <b>33</b> yrs.)	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Company</b>			11. BIRTHPLACE (State or foreign country) <b>Frost, West Virginia</b>		
13. FATHER'S NAME <b>Jacob Mace</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Kelley</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO <b>217-24-0034</b>			17. INFORMANT <b>Clin. Rec., Vet Adm Hosp, Ft. Howard, Md.</b>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RHEUMATIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>
416X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Freeland	(County) Maryland	(State)

21. I certify that I attended the deceased from July 10, 1957, to July 10, 1957, and that death occurred at 1:15 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Irving Freeman</i>	M.D.	ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MARYLAND					
DATE SIGNED 7/11/57							
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>							

22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF <b>7-13-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Zion Methodist Church</b>	22d. LOCATION (City, town, or county) <b>Freeland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Bright Inc.</i>		ADDRESS Wm. Cook-Bright, Inc., 6009 Harford Rd., Balt., Md.	24a. REC'D BY REGISTRAR DATE <b>7/12/57</b>
			24b. REGISTRAR'S SIGNATURE <i>Dr. Daniel Farber</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 will be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)

15M 9/55

Shipped:  
By Hearse By

BUREAU V. S.

JUL 15 19

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

071889

07207

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glencoe</i>		c. LENGTH OF STAY IN lb <i>40 yrs.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) d. STATE <i>Md.</i>		b. COUNTY <i>Baldo.</i>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X: Glencoe</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Glencoe Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>James</i>	Middle <i>Thomas</i>	Last <i>Martin</i>	4. DATE OF DEATH <i>July 18 1957</i>	Month <i>July</i>	Day <i>18</i>	Year <i>1957</i>	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 20, 1866</i>	9. AGE (In years last birthday) <i>90 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General Merchants</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Charles E. Martin</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Goodwin</i>					Address <i>Glencoe</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-32-1303</i>		17. INFORMANT <i>Charles Martin</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>generalized arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Coatesville, Md.</i>		20f. (City or town) <i>Coatesville</i>		(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>July 11, 1957</i> to <i>July 18, 1957</i> , that I last saw the deceased alive on <i>July 15, 1957</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>Coatesville, Md.</i>									
DATE SIGNED <i>Elizabeth B. Sherrill M.D.</i>									
ACTUAL SIGNATURE <i>Elizabeth B. Sherrill M.D.</i>		PHYSICIAN'S NAME (Type) <i>Elizabeth B. Sherrill M.D. Coatesville, Md.</i>							
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>7-21-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Herford Baptist</i>		22d. LOCATION (City, town, or county) <i>Herford Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. Scott Brooks, 673 York Rd. Towson, Md.</i>		ADDRESS <i>Directed to funeral director</i>		24a. REC'D BY REGISTRAR <i>JUL 22 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth Gorouch</i>			

REGISTRY

JUL 22 1957

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

07129

## CERTIFICATE OF DEATH

07159

Reg. Dist. No. 41

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b Dundalk, 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Woodland Avenue		e. STREET ADDRESS 15 Woodland Avenue	
3. NAME OF DECEASED (Type or print) Stephen		Last Martin	4. DATE OF DEATH July 16 Year 1957
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Bethlehem Steel		9. AGE (In years lost birthday) yrs. 72	10. IF UNDER 1 YEAR Months Days Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs. Mary Sterling, 15 Woodland Ave, Dundalk 22	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs -	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		A-S-C-V Disease	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 16</u> , 19 <u>57</u> , to <u>July 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. <u>10800 Maryland Ln</u> Physician's NAME (Type) <u>M. B. Davis M.D.</u> Dundalk, Md 7/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-20-57	22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery	22d. LOCATION (City, town, or county) Dundalk 22, Md (State)
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc 1217 St. Paul Street		24a. REC'D BY REGISTRAR Date 22-1053	
		24b. REGISTRAR'S SIGNATURE <u>J. Kelly</u>	

BUREAU V. S.  
RECEIVED  
JUL 22 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07190

07208

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; page 1 and 2 should be filed with the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>18. Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		d. STREET ADDRESS <b>7803 Oakdale Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7102 York Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>CORA</b>	Middle <b>MAY</b>	Last <b>MASON</b>	4. DATE OF DEATH	Month <b>July</b>	Day <b>21,</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>May 10, 1891</b>	9. AGE (In years from birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months <b>66</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>private duty</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Bion H. Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Helen Walker</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>215-32-4396</b>		17. INFORMANT <b>Mrs. Geo. Seward - 7102 York Rd.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>156.1</b>		<i>Metastatic carcinoma of liver</i>		INTERVAL BETWEEN ONSET AND DEATH <b>7 mos.</b>	
(b) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. <b>156.1</b>		(c)		<i>Primary carcinoma of breast.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>10:30 P.M.</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1101 St. Paul St. Balt 2-1142</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>57</b> , to <b>July</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-21</b> , 19 <b>57</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Alfred G. Ossman, Jr. M.D.</b> DATE SIGNED <b>7-24-57</b>							
ACTUAL SIGNATURE <i>Alfred G. Ossman, Jr.</i>		PHYSICIAN'S NAME (Type) <b>Alfred G. Ossman, Jr. M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/47</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Johns Cem.</b>		22d. LOCATION (City, town, or county) <b>Howard Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stan J. Lissner &amp; Sons - Balt 2-1142</i>		ADDRESS <b>1101 St. Paul St. Balt 2-1142</b>		24a. REC'D BY REGISTRAR DATE <b>7/24/57</b>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

BUREAU V.

JUL 25 1957

REGELY ED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07191	38		
07299 CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY <b>Balto Co. MD MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>					b. COUNTY <b>Balto Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>			c. LENGTH OF STAY IN TB <b>RURAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>			d. STREET ADDRESS <b>3325 Willoughby Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3325 Willoughby Rd</b>													
3. NAME OF DECEASED (Type or print)		First <b>WILBERT</b>	Middle <b>H.</b>	Last <b>MATTES</b>	4. DATE OF DEATH		Month <b>July</b>	Day <b>31</b>	Year <b>1957</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>DEC 1, 1911</b>	9. AGE (In years, last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months <b>0</b>		11. IF UNDER 24 HRS. Days <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>HERMANN MATTES</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE MOLLE</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-05-7644</b>		17. INFORMANT <b>MRS W. N. MATTES 3325 Willoughby Rd</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinoma of Sinus & widespread metastasis			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO											
(c)		DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>X</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>X</b>		20f. (City or town) <b>X</b>		(County)		(State)			
21. I certify that I attended the deceased from <b>7/29</b> , 1957, to <b>7/31</b> , 1957, that I last saw the deceased alive on <b>7/29</b> , 1957, and that death occurred at <b>8 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>W. Thomas Lloyd</b>								ADDRESS (Street, city or town, state) <b>9005 Hartford Rd</b>		DATE SIGNED <b>1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/3/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. John Evan Luth Cem</b>		22d. LOCATION (City, town or county) <b>Balto Co</b>		(State) <b>MD</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles St. James</b>		ADDRESS <b>8802 Hayfield Rd</b>			24a. REC'D BY REGISTRAR <b>DAG 2</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. R. M. Bacon</b>						

RECEIVED  
JULY 2 1957

SEARCHED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07192

07210

## CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (Rural)	c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) / Sparks (Rural)	d. STREET ADDRESS Quaker Bottom Rd.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Quaker Bottom Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  W.A. Matthews	First Irving	Middle Waugh	Last Matthews
4. DATE OF DEATH July 2	Month July	Day 2	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-1900
9. AGE (in years last birthday) 56	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER, operator	10b. KIND OF BUSINESS OR INDUSTRY real estate	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harry A. Matthews		14. MOTHER'S MAIDEN NAME Dora Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT 217-26-9577 Margaret Matthews, Sparks, Md.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE G. M. France M.D.		ADDRESS (Street, city or town, state) PARKTON, MD DATE SIGNED 7/2/57	
22a. BURIAL, CREMATION, REMANENT (Secty)		22b. DATE THEREOF 7-5-57	22c. NAME OF CEMETERY OR CREMATORIUM Friends Meeting
22d. LOCATION (City, town, or county) Sparks, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service		24a. ADDRESS 622 York Rd. Towson 4, Md.	24b. REC'D BY REGISTRAR DATE July 8 1957
		24b. REGISTRAR'S SIGNATURE Eliz. Grusich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be forwarded to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the Burial-Cremation permit. Then please remove carbon papers. Pages 1 & 2 should be retained with this certificate.

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1957

CEAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07193

07211

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be delivered for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled in by the funeral director, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
1SM 9/55

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN 1b		d. STATE <b>MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		b. COUNTY <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>		First <b>GEORGE</b> Middle		d. STREET ADDRESS <b>2314 SIDNEY AVENUE, BALTO 30</b>	
4. SEX <b>MALE</b>		5. COLOR OR RACE <b>WHITE</b>		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. DATE OF BIRTH <b>9-10-1889</b>		8. AGE (In years last birthday) <b>67 yrs.</b>		9. IF UNDER 1 YEAR Months <b>7</b> Days <b>26</b> Hours <b>1957</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage/Av.</b>		11. BIRTHPLACE (State or foreign country) <b>V.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>CONRAD MAURER</b>		14. MOTHER'S MAIDEN NAME <b>THERESA RITTER</b>		Address <b>Hospital Records, Mt. Wilson State Hospital</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FAR ADVANCED PULMONARY TUBERCULOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 monthly</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>0120</b>					
(b) _____					
DUE TO _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>TUBERCULOSIS OF THORACIC AND LUMBAR/SPINE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>_____</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>	
20f. (City or town) <b>_____</b>		(County) <b>_____</b>		(State) <b>_____</b>	
21. I certify that I attended the deceased from <b>5-1, 1957, to 7-26, 1957</b> , that I last saw the deceased alive on <b>7-26, 1957</b> , and that death occurred at <b>7:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>_____</b>					
DATE SIGNED <b>_____</b>					
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>7-30-57</b>		22b. DATE THEREOF <b>7-30-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lodden Park</b>	
22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>See Cemetery Funeral Home</b>		ADDRESS <b>_____</b>		24a. RECD BY REGISTRAR DATE <b>_____</b>	
24b. REGISTRAR'S SIGNATURE <b>Dorothy Powell</b>					

BUREAU V.

JUL 29 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07212

## CERTIFICATE OF DEATH

Reg. Dist. No.

17194

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>5yr11mth14dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Linthicum, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Peter</b>	Middle <b>Francis</b>	Last <b>Maxa</b>	4. DATE OF DEATH	Month <b>July</b>	Day <b>4</b>	Year <b>1957</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8, 1871</b>		9. AGE (In years last birthday) <b>85 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Pilsen, Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic cardiovascular disease		DUE TO DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hand</b>					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Brooklyn, N.Y.</b>	(County) (State)
21. I certify that I attended the deceased from <b>July 12, 1957</b> , to <b>July 4, 1957</b> , that I last saw the deceased alive on <b>July 4, 1957</b> , and that death occurred at <b>7:50a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Stella Wachsler, M.D.</b> DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 7-4-57</b>							
ACTUAL SIGNATURE <b>Stella Wachsler</b>		PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/8/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Brooklyn, N.Y.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGilly Funeral Homes</b>		ADDRESS <b>130 E. Fort Ave. "30</b>		24a. REC'D BY REGISTRAR <b>JUL 8 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Leach</b>	

BUREAU V.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
07213 CERTIFICATE OF DEATH

07195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<b>BALTIMORE</b> <b>MARYLAND</b>		<b>MARYLAND</b> <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b <b>Catoctinville</b> <b>21 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 22</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. STREET ADDRESS <b>SPRING GROVE</b> <b>1917 DUNDALK AVE.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>SARAH</b>	Middle <b>BELLE</b>	Last <b>MC CAFFREY</b>
4. DATE OF DEATH	Month <b>7</b>	Day <b>7</b>	Year <b>1957</b>
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-20-1876</b>
9. AGE (In years last birthday) <b>80</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALTWOMAN (rtd)</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or Foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>ROBERT LITTLE</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH <del>HAMILTON</del></b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-12-1536</b>	
17. INFORMANT <b>ELIZABETH KNIGHT</b>		Address <b>1917 Dundalk Ave, Baltimore</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<b>Afteriosclerotic coronary thrombosis</b>	
(b) DUE TO		<b>generalized arteriosclerosis</b>	
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Diabetes mellitus</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-7-1957</b> to <b>7-7-1957</b> , that I last saw the deceased alive on <b>7-7-1957</b> , and that death occurred at <b>455 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bruno Radauskas</b>		ADDRESS (Street, city or town, state) <b>Spring Grove St. Hosp.</b>	
PHYSICIAN'S NAME (Type) <b>Bruno RADAUSKAS</b>		DATE SIGNED <b>7/7/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/10/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Darlington Cemetery</b>		22d. LOCATION (City, town, or county) <b>Darlington, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Tinkner &amp; Sons - Baltimore Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 10 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

BUREAU Y.

JUL 10 1957

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07214

## CERTIFICATE OF DEATH

07196

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Balto.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Overlea

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

5231 Trumps Mill Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  
a. STATE

Md.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Overlea

d. STREET ADDRESS

5231 Trumps Mill Rd.

e. IS RESIDENCE ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

F.

6. COLOR OR RACE

W.

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

Dec 14 1884

9. AGE (in years  
last birthday)

72 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James McCann

14. MOTHER'S MAIDEN NAME

Mary Jane Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None Anna B. Schuster 5231 Trumps Mill Rd.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause first.

(b)

DUE TO

(c)

Arterosclerotic vascular  
diseaseINTERVAL BETWEEN  
ONSET AND DEATH

7 yrs

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19 p. m.20d. INJURY OCCURRED  
While Not while  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Sept 12, 1917, to July 6, 1917, that I last saw the deceased  
alive on July 2, 1917, and that death occurred at 4:30 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

M.D.

PHYSICIAN'S  
NAME (Type)

1 W. OVERLEA AVE 7117

Baltimore 6-1461

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. RECED. BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

RECEIVED  
MAY 9 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07197  
-37

07215

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b>		c. LENGTH OF STAY IN lb <b>53 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		d. STREET ADDRESS <b>9 CHURCH LANE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 CHURCH LANE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>KATHERINE ECKENRODE McKIM</b>		First	Middle	Last	4. DATE OF DEATH <b>July 31,</b>	Month	Day	Year <b>1957</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>JULY 3, 1869</b>	9. AGE (In years from birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ADAMS CO. PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>HENRY ECKENRODE</b>		14. MOTHER'S MAIDEN NAME <b>MARIA CLUNK</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. KATHERINE CHALMERS, 9 CHURCH LANE Md.</b>		Address <b>Pikesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Myocardial Infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)	<i>Arteriosclerotic Heart Disease</i>		DUE TO (c)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from <i>March 12, 1957</i> to <i>July 30, 1957</i> , that I last saw the deceased alive on <i>July 30, 1957</i> , and that death occurred at <i>11:30 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Pikesville, Md.</i>							DATE SIGNED <i>Aug, 1957</i>
ACTUAL SIGNATURE <i>Waverly S. Green Jr.</i>									
PHYSICIAN'S NAME (Type) <b>Waverly S. Green Jr., M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-3-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>ST. CHARLES</b>		22d. LOCATION (City, town, or county) <b>PIKESVILLE, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Waverly S. Green Jr., Pikesville, Md.</i>		ADDRESS <b>Dorothy Newell</b>							
		24a. REC'D BY REGISTRAR DATE <b>JUG 5 1957 Dorothy Newell</b>							
		24b. REGISTRAR'S SIGNATURE							

UREAU V. S.

AUG 5 1967

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07216

## CERTIFICATE OF DEATH

Reg. Dist. No.

07198

33

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>392 Butler Road</b>		d. STREET ADDRESS <b>392 Butler Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Margaret</b>	Middle <b>J.</b>	Last <b>Merkel</b>	4. DATE OF DEATH <b>July 20, 1957</b>	Month <b>July</b>	Doy <b>20</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 2, 1915</b>	9. AGE (In years last birthday) <b>41</b>	IF UNDER 1 YEAR Months <b>41</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Carlisle</b>		14. MOTHER'S MAIDEN NAME <b>Annie Berry</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>526-34-1714</b>		17. INFORMANT <b>Leon C. Merkel, Reisterstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanomatosis</b> <b>190X</b>		DUE TO <b>Melanoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>None</b>		DUE TO <b>None</b>		(c) <b>None</b>		<b>2 1/2 yrs.</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE BY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>none 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> <b>None</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. (City or town) <b>None</b>	(County)	(State)		
21. I certify that I attended the deceased from <b>1-16-56</b> , 19 <b>56</b> , to <b>7-20-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-12-57</b> , 19 <b>57</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>D. D. Caples</b>		ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b>		DATE SIGNED <b>7-22-57</b>			
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		Reisterstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 23/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Jessop's</b>	22d. LOCATION (City, town, or county) <b>Cockeysville, Md.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>7-22-57</b>	24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Loge 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

11-99 1957

RECEIVED

07199

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
07217 CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH ■ COUNTY <b>Baltimore (Essex)</b>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>360 Townsend Road,</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex, Maryland</b>				d. STREET ADDRESS <b>360 Townsend Road.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home 360 Townsend Road.,</b>																	
3. NAME OF DECEASED (Type or print)		First <b>Evelyn</b>		Middle <b>Martha</b>		Last <b>Merling</b>		4. DATE OF DEATH		Month <b>7</b>		Day <b>2</b>		Year <b>19 57</b>			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <b>37 yrs</b>		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
<b>Female</b>		<b>White</b>		<b>WIDOWED <input type="checkbox"/></b>		<b>DIVORCED <input type="checkbox"/></b>		<b>4/9/20</b>		Months <b>37</b>		Days <b>0</b>		Hours <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>					
13. FATHER'S NAME <b>Love</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>				17. INFORMANT <b>(Husband) Frank A.</b>				Address <b>360 Townsend Road.,</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b>																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from <b>July 1, 1952</b> , to <b>July 2, 1952</b> , that I last saw the deceased alive on <b>July 1, 1952</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Joseph Miceli</i> M.D.								ADDRESS (Street, city or town, state)				DATE SIGNED <b>7/6/67</b>					
PHYSICIAN'S NAME (Type) <b>Joseph Miceli, M.D.</b>				108 S. Taylor Ave., Essex 21, Md.													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/6/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) <b>German Hill Road., Baltimore, Md.</b>		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Connolly</i>				ADDRESS <b>418 Eastern Ave. Essex, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JULY 8 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Edith Starkey</i>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 7, 8, & 9 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUZLUDJA V. 2

1000

THE SERIES

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07218

## CERTIFICATE OF DEATH

07200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5yrlmthldy</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>Washington &amp; Penn. Avenues</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Benjamin</b>	Middle <b>Benson</b>	Last <b>Merryman</b>	4. DATE OF DEATH Month <b>7</b>	Day <b>16</b>	Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2, 1876</b>	9. AGE (in years last birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>81</b>	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Merryman</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Cross</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-18-8696</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b>						INTERVAL BETWEEN ONSET AND DEATH	
14200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO (b) <b>Anteriorisclerotic heart disease</b>					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f (City or town) (County) (State)</b>			
21. I certify that I attended the deceased from <b>July 5, 1957</b> to <b>July 16, 1957</b> , that I last saw the deceased alive on <b>7/16, 1957</b> , and that death occurred at <b>8:25 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>7/16/1957</b>	
ACTUAL SIGNATURE <b>Bruno Radauskas</b>		M.D.		SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) <b>Bruno Radauskas</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. J. S. S.</b>		ADDRESS <b>Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. C.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached for use as the burial-tombstone permit. Then please remove carbon paper. Pages 1-2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. MAIL

REGISTRATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be filed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07219

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

07201

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
				a. STATE Maryland	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write <small>Suburb, etc., give nearest town</small> ) Hampstead Rural		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead, Maryland x. Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Black Rock Road				d. STREET ADDRESS Black Rock Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John	Middle S	Last Merryman	4. DATE OF DEATH July
				Month Month	Day 28
				Year Year	
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 6, 1893	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. Merryman		14. MOTHER'S MAIDEN NAME Rosella K. Armacost			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes, no, or unknown)</small> No		16. SOCIAL SECURITY NO. 301-10-7521		17. INFORMANT Blanche Martin Hampstead <small>deceased</small>	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH ?	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Coronary Heart Disease					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. --- 19 p.m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27, 1957, to July 29, 1957, that I last saw the deceased alive on July 27, 1957, and that death occurred at 3: A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Hampstead, Md 21079/57	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Joseph E. Bush M.D.		M.D.		DATE SIGNED 7-29-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 1/57		22c. NAME OF CEMETERY OR CREMATORIAL Grace	
22d. LOCATION (City, town, or county) Baltimore Co Md					
23. FUNERAL DIRECTOR'S SIGNATURE Edwin Gipton Hampstead Md		ADDRESS		24a. REC'D BY REGISTRAR DATE 7-28-57	
				24b. REGISTRAR'S SIGNATURE Mary B. Elime	

RECEIVED  
BUREAU V. 8

APR 22 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07134

## CERTIFICATE OF DEATH

Reg. Dist. No.

07202  
44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5642 Carville Ave		d. STREET ADDRESS 5642 Carville Ave / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAWRENCE F LOUIS MILAN (also MILANO)		First	Middle
		Last	4. DATE OF DEATH July 26, 1957
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Route Owner		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Dominick Milan		14. MOTHER'S MAIDEN NAME Victoria	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 213-16-423	17. INFORMANT Katherine M. Milan, 5642 Carville Ave Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
<i>✓</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>Carcinoma of lung</i>	
DUE TO (b)			
DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 27</i> , 1957, to <i>July 26</i> , 1957, that I last saw the deceased alive on <i>July 23</i> , 1957, and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>400 Wilkens Ave</i> DATE SIGNED <i>7-27-57</i>	
ACTUAL SIGNATURE <i>E. EARL PASS M.D.</i>		PHYSICIAN'S NAME (Type) <i>E. EARL PASS, M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-57	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE <i>JUL 31 1957</i> <i>Julia M. Huffy</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 31 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07203

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		7220 Item 2 (Rev. 1-57 ed.)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Catonsville 28 md</i>		MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Catoonsville 28		5 yrs.		Arbutus 28181 MD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Oak Hill Nursing Home		1305 Birch Ave			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Charles Hunt Miller SR.					JULY 31 1957
S SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Male	White	WIDOWED <input checked="" type="checkbox"/>	NOV 27 1866	90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS, OR/INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Telephone Installer		Telephone		Washington, D.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jacob Miller		Ellen Martin		U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT  Mrs. Nina Brunner, 1305 Birch Ave. Arbutus MD	
Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fractures Compound Multiple Skull		INTERVAL BETWEEN ONSET AND DEATH None	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)			
DUE TO		(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Enter nature of injury in Part I—Part II of item 19.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Carcinoma of throat (Cobalt therapy)		PT jumped off Roof			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED PT jumped off Roof		20c. TIME OF INJURY Month, Day, Year 4:00 p.m. 7/31/57	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home		20f. (City or town) Catoonsville 28 md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> W. E. McGrath M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>W. E. McGrath</i>				DATE SIGNED 7/31/57	
EXAMINER'S NAME (Type)		22b. DATE THEREOF Aug. 3/57		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park	
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial		22e. LOCATION (City, town, or county) Lutherville		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave Baltimore		ADDRESS 4101 Edmondson Ave		24a. REC'D BY REGISTRAR AUG 25 1957	
				24b. RECORDS SIGNATURE AUG 25 1957	

LEAU V. S.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 07221 CERTIFICATE OF DEATH

07204

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7806 Oak Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Miller	Last July 17, 1957
4. DATE OF DEATH	Month July	Day 17	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1864
9. AGE (In years lost birthday) 92 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown Braun		14. MOTHER'S MAIDEN NAME Henrietta M. Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT No		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO	
		Coronary occlusion arterosclerotic cardiovascular syndrome 1 year INTERVAL BETWEEN ONSET AND DEATH 7 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ July 14, 1957, to _____ July 17, 1957, that I last saw the deceased alive on _____ July 17, 1957, and that death occurred at 6:10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE E. J. Alessi, M. D.		ADDRESS (Street, city or town, state) 6217 Hartford Rd DATE SIGNED 7/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Green Mount		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lassalle Funeral Home		24a. REC'D BY REGISTRAR DATE 22 JUN 1957	
ADDRESS 7401 Belair Rd		24b. REGISTRAR'S SIGNATURE Dr. G. M. Bacons	

BUREAU V. S.

JUL 29 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07205

07222

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b>		c. LENGTH OF STAY IN lb <b>10 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3V21-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1929 Maisel Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>JAMES</b>	Middle <b>(NMI)</b>	Last <b>MOORE</b>	4. DATE OF DEATH <b>July</b>	Month <b>8</b>	Day <b>19</b>	Year <b>57</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/12/94</b>	9. AGE (in years [last birthday]) <b>62</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cotton Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Greensburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.A.A.</b>		
13. FATHER'S NAME <b>Charles Moore</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Lingie</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clin. Rec. Folder. Vet. Adm. Hosp., Ft. Howard, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bladder Calculus. Cystitis</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VAH, Fort Howard, Md.</b> (County) <b>7/8/57</b> (State)		
21. I certify that <b>VAH</b> attended the deceased from <b>June 28, 1957</b> to <b>July 8, 1957</b> , and that death occurred at <b>7:25 P.M.</b> from the causes and on the date stated above.								
X <b>Signature</b> <b>M.D.</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, Fort Howard, Md.</b> <b>7/8/57</b>								
ACTUAL SIGNATURE <b>GARFIELD D. KINGSTON, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-11-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook - Blight Bros.</b>		ADDRESS <b>Wm Cook Blight Funeral Home, St. Paul &amp; Preston Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>7/12/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Daniel Passen</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use of the burial-troune permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 15 1970

REGEVIEW

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07206

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	c. LENGTH OF STAY IN 1b 10 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Academy Ave.		d. STREET ADDRESS Academy Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EVA	First MIDDLE ST. CLAIR	Last MOSS	4. DATE OF DEATH July 9 1957			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1895			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Pvt. family	9. AGE (in years at birthday) 62 yrs.			
11. BIRTHPLACE (State or foreign country) Gwynbrook, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME James Branson		14. MOTHER'S MAIDEN NAME Nannie Davis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Viola Eley, 502 Pleasant Hill Rd., Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary anemia</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca. of stomach</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-4 mos. 1 yr.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) none	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>D. D. Caples</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 7-11-57		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 13 July '57	22c. NAME OF CEMETERY OR CREMATORIUM MT. PLEASANT	22d. LOCATION (City, town, or county) OWINGS MILLS, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Halladay Funeral Home</i>		ADDRESS 1651 Druid Hill Ave.		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE 16 1957 <i>Mary Eley</i>	

TO DUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please give the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. To Funeral Director: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any document is required, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

**TO DEP**  
Cut it  
Forward  
**TO FUN**

VS. ATSMF  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07207

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
				a. STATE <b>Maryland</b>	b. COUNTY <b>Baltimore</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
				d. STREET ADDRESS <b>3156 WOODRING AVE.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sparrows Point Hospital</b>					
3. NAME OF DECEASED (Type or print)		First <b>Camillo</b> Middle <b>John</b>		4. DATE OF DEATH Month <b>7</b> Day <b>27</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-20-91</b>	9. AGE (In years yrs.) <b>65</b>	10. IF UNDER 1 YEAR Months <b>9</b> Days <b>6</b> Hours <b>0</b> Min <b>0</b> IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ship Driller</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>	11. BIRTHPLACE (State or foreign country) <b>Torano Nuovo-Teramo-Italy</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Dominic Muscello</b>	14. MOTHER'S MAIDEN NAME <b>Rosa Di Giantomaso</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>213-07-0133</b>	17. INFORMANT Address <b>Mary Muscello (Wife) 3156 Woodring Ave</b>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fractured skull. Subluxation of right ankle. Almost complete avulsion of glans penis.</b>		
X <b>DUY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b>		D.O.A.
DUE TO (b) <b></b>		
DUE TO (c) <b></b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by an automobile on Shipyard Road, near Flange Mill</b>				
20c. TIME OF INJURY Hour <b>7:55</b> p.m. Month, Day, Year <b>7-27-57</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>B.E. Shipyard Road</b>	20f. (City or town) <b>Sparrows Point</b>	(County) <b>Baltimore Md.</b>	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .
--

ACTUAL SIGNATURE <b>M.B. Davis</b>	DATE SIGNED <b>7-27-57</b>
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 30 1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Lorraine Park Mausoleum</b>	22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Deller Rose 322 S. High St.</b>	ADDRESS <b>JUL 29 1957</b>	24. REC'D BY REGISTRAR <b>7-27-57</b>	24. REGISTRAR'S SIGNATURE <b>Lawrence L. Farley</b>
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BUREAU V. S

JUL 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, 15, 16, 17-18-57 et

17208

07225

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8031 Highpoint Road</b>		e. STREET ADDRESS <b>8031 Highpoint Road</b>	
3. NAME OF DECEASED (Type or print) <b>Mr. Peter Paul Mutchok</b>		First <b> </b>	Middle <b> </b>
4. DATE OF DEATH <b>July 10th 1957</b>		Month <b>July</b>	Day <b>10th</b>
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Oct. 27, 1917</b>		9. AGE (In years lost birthday) <b>39 yrs</b>	10. UNDER 1 YEAR Months <b> </b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b> </b>	10c. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
11. CITIZEN OF WHAT COUNTRY? <b>USA</b>		12. FATHER'S NAME <b>Charles Mutchok</b>	
13. MOTHER'S MAIDEN NAME <b>Mary (Last name unknown)</b>		14. INFORMANT <b>Mrs. Mary Mutchok, 8031 Highpoint Road.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b> </b>		16. SOCIAL SECURITY NO. <b> </b>	
17. INFORMANT <b> </b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Central Nervous System</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Essential hypertension</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>25 minutes</b> Several years	
19. MEDICAL CERTIFICATION <b>444A</b>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b> </b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b> </b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b> </b>	
20c. TIME OF INJURY Month, Day, Year Hour e. m.      19 p. m. <b> </b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b> </b>		20f. (City or town) (County) (State) <b> </b>	
21. I certify that I attended the deceased from <b>July 10, 1957</b> , to <b>July 10, 1957</b> , that I last saw the deceased alive on <b>July 10, 1957</b> , and that death occurred at <b> </b> , M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>Elliott Harris</b> PHYSICIAN'S NAME (Type) <b>Dr. S. Elliott Harris</b>		ADDRESS (Street, city or town, state) <b>8100 Harford Road</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/11/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>7/12/57</b>	
		24b. REGISTRAR'S SIGNATURE <b>D. A. M. Bacon</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 12 1957

SEARCHED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07226

## CERTIFICATE OF DEATH

07209

Reg. Dist. No. 38

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Baltimore		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6311 Mossway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) J. Ross Myers Jr.		First	Middle
4. DATE OF DEATH July 13	Month	Day	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1901
9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ch. of board		10b. KIND OF BUSINESS OR INDUSTRY Bakery Supplies	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME J. Ross Myers		14. MOTHER'S MAIDEN NAME Emma Barnitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. J. Ross Myers	
17. INFORMANT Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF BRAIN 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHIOGENIC CARCINOMA OF BRAIN DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>July 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>57</u> , and that death occurred at <u>4:30 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John M. Scott</u>		M.D.	
PHYSICIAN'S NAME (Type) John M. Scott		8 Longwood Road 10	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15 1957	22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge
22d. LOCATION (City, town, or county) Pikesville Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Tickner &amp; Sons - Balt 17</u>		24a. ADDRESS <u>110</u>	24b. REC'D BY REGISTRAR DATE 7/15/57
		24b. REGISTRAR'S SIGNATURE <u>Mabel Grimes</u>	

RECEIVED  
BUREAU V. S.

JUL 19 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07227

## CERTIFICATE OF DEATH

Reg. Dist. No.

07210

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wayne Convalescent Home 98 Smithwood Avenue		d. STREET ADDRESS 24 Sanford Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wilhelmine L. Neuman		First	Middle		
		Last	4. DATE OF DEATH Month July Day 21 Year 1957		
S. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 7, 1871		
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years (last birthday) yrs. 86	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT George F. Neuman, 24 Sanford Ave, Catonsville	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) } DUE TO		Degenerative Heart Disease with Atrial Fibrillation.			
} (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 32. Confusions following incident to fall after stroke				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1303 Frederick Ave. Catonsville 28 md	
ACTUAL SIGNATURE <i>JK Mc Greath</i>		M.D.		DATE SIGNED 7/31/57	
PHYSICIAN'S NAME (Type) W. E. Mc Greath					
22a. BUR. AL. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-57		22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery	
22d. LOCATION (City, town, or county) Baltimore County				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DAEUL 24 '57	
				24b. REGISTRAR'S SIGNATURE <i>Alfred Cook</i>	

RECEIVED  
BUREAU V.

JUL 9 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07228

## CERTIFICATE OF DEATH

Reg. Dist. No.

072131

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1921 Gwynn Oak Ave</b>		d. STREET ADDRESS <b>1921 Gwynn Oak Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Rose</b>	Middle <b>A.</b>	Last <b>Nolan</b>
4. SEX <b>Female</b>	5. COLOR OR RACE <b>White</b>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>May 1, 1888</b>
8. AGE (In years last birthday) <b>69 yrs</b>	9. IF UNDER 1 YEAR Months <b>6</b>	10. IF UNDER 24 HRS Days <b>9</b>	11. Year <b>1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dennis Walsh</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Byrne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>— Mr. Patrick J. Nolan - 1921 Gwynn Oak</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerosis</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>Month</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, and that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Milton Schlesinger, M.D. 6410 Windsor Mill Rd.</b>	
ACTUAL SIGNATURE <b>Milton Schlesinger</b>		DATE SIGNED <b>7/20/57</b>	
PHYSICIAN'S NAME (Type) <b>Milton Schlesinger</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 23, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>New Catharal</b>		22d. LOCATION (City, town, or county) <b>Balto.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6410 Windsor Mill</b>	
		24a. REC'D BY REGISTRAR <b>JUL 23 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>John T. Stansbury</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 8

תלמוד בבלי מס' 83 ע' 11 ברכות נזקן

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07212  
38

Reg. Dist. No.

07229

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrars prior to burial, cremation, or removal.

VS. A15ME[5]  
SM 9/55

1. PLACE OF DEATH a. COUNTY  Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x0 Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bendix Corp		d. STREET ADDRESS 7551 Berkshire Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mr. Le Roy Hall Nowell	Middle	Last
4. DATE OF DEATH	Month July	Day 11th	Year 1957
5. SEX	6. COLOR OR RACE male white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH Sept 9, -1913
8. AGE (In years last birthday) 43 yrs.	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	11. IF UNDER 24 MINS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly Mechanic		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Nowell		14. MOTHER'S MAIDEN NAME Elsie M. Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-02-5603	
17. INFORMANT Mrs. Mary E. Nowell, 7551 Berkshire Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusions			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F O'Donnell		DATE SIGNED 7/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/57	
22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE JUL 16 1957	
		24b. REGISTRAR'S SIGNATURE Mabel Guy	

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PURCHASED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07230

## CERTIFICATE OF DEATH

07213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 316 N. Athol Ave. - Apt. B		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First IRENE	Middle E.	Last OSBOURN	4. DATE OF DEATH July 3,	Month Year Day Year 19 57
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1890	9. AGE (In years from birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME William Blackford Osbourn		14. MOTHER'S MAIDEN NAME Charlotte Kratz		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. William E. Osbourn, Jr.-3512 Essex Rd. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple metastases from carcinoma of left breast  DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 1956 to July 3, 1957, that I last saw the deceased alive on July 3, 1957, and that death occurred at 3:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE George A. Knipp, M.D. PHYSICIAN'S NAME (Type) M.D. 4116 Edmondson Avenue DATE SIGNED 7/5/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Pickering & Sons - Baltimore		ADDRESS JUL 5 '57		24a. REC'D BY REGISTRAR DATE JUL 5 '57	
				24b. REGISTRAR'S SIGNATURE R. L. S.	

**TO HOSPITAL**  **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SCHEAU V. S.

SCHEAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07231

## CERTIFICATE OF DEATH

07214

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>BALTO</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT.</u> (19)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>908 H STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE SHIPLEY</u>		First <u>SHIPLEY</u>	Middle <u>OWENS</u>
4. DATE OF DEATH <u>7-15-1957</u>		Month <u>July</u>	Day <u>15</u>
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>MAY 5, 1896</u>		9. AGE (In years (last birthday) yrs.) <u>61</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ADMITTED</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>V.I.S. A.</u>			
13. FATHER'S NAME <u>W.M. SHIPLEY</u>		14. MOTHER'S MAIDEN NAME <u>MATILDA THORNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>G.N. CROWELL</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Dystrophy</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO <u>1 yr.</u> (c) <u></u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>514 C. ST. SPARROWS PT. 19, MD.</u>
20f. (City or town) <u>MD.</u>		(County) <u>514 C. ST. SPARROWS PT. 19, MD.</u>	
(State) <u>MD.</u>		(State) <u>MD.</u>	
21. I certify that I attended the deceased from <u>OCT. 20</u> , 1956, to <u>JULY 15</u> , 1957, that I last saw the deceased alive on <u>JULY 15</u> , 1957, and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>J.T. Means.</u>		ADDRESS (Street, city or town, state) <u>514 C. ST. SPARROWS PT. 19, MD.</u>	
		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>J.T. MEANS - 514 C ST. SPARROWS PT. 19, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/18/57</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>BALTO. NATIONAL</u>
22d. LOCATION (City, town, or county) <u>BALTO. MD.</u>		(State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bentz Bradley, Dundalk, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>18 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Lewison L. Farley</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 19 1957

BUREAU V. A.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07215

## 07232 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>116 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>537 Moore Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JAMES</b>	Middle <b>L</b>	Last <b>PARKER</b>	4. DATE OF DEATH <b>July 23 1957</b>	Month <b>July</b>	Day <b>23</b>	Year <b>1957</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 6, 1922</b>	9. AGE (In years last birthday) <b>35 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Huckster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Parker</b>		14. MOTHER'S MAIDEN NAME <b>Helen Brown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WWII Unknown</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162X</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		BRONCHIOGENIC CARCINOMA WITH METASTASIS		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b>	(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>March 29, 1957</b> , to <b>July 23, 1957</b> , and that death occurred at <b>11:55 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>							
DATE SIGNED <b>7/24/57</b>							
ACTUAL SIGNATURE <b>Harold R. Johnson</b>							
PHYSICIAN'S NAME (Type) <b>HAROLD R. JOHNSON, M.D.</b>							

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jul 29</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Adelphus Halstead Funeral Home, 918 Druid Hill Ave.</b>		ADDRESS <b>Baltimore 1, Maryland</b>	24a. REC'D BY REGISTRAR <b>JUL 25 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Denson L. Parker</b>

BUREAU V.

JUL 25 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07216

07233

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3626 Estler Place	
3. NAME OF DECEASED (Type or print)	First Gail	Middle Fern	Last Pasterfield
4. DATE OF DEATH	Month 7	Day 23	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leroy Pasterfield	
14. MOTHER'S MAIDEN NAME Mary Altavater		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Parents and Rosewood records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inspiratory Pneumonia</u>  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Edema plus with complicating quadriplegia</u>  DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 6, 1955</u> , to <u>July 23, 1957</u> , that I last saw the deceased alive on <u>July 23, 1957</u> , and that death occurred at <u>9:00 p.m.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE: <u>Harry G. Butler</u> ADDRESS (Street, city or town, state) M.D. Owings Mills, Maryland DATE SIGNED 7/21/57			
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Rosewood State Training School	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery	22d. LOCATION (City, town, or county) Baltimore (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran 3000 E. Baltimore St. Baltc		ADDRESS	24a. REC'D BY REGISTRAR DATE 7/24/57
			24b. REGISTRAR'S SIGNATURE Mary Elvarez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PERIODICALS  
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JUL 26 1957

PERIODICALS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07217

## (7234) CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)	
BALTIMORE				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		MARYLAND BALTIMORE	
TOWSON		3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		COCKEY'SVILLE	
TOWSON CONVAL. HOME		WARREN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
CLED A			WELSH	PEPPLER	JULY 14 1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
FEMALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DEC. 31, 1889	67 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				OHIO	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
THOMAS WELSH		OLA PAINTER		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
NO		214-22-5615		EDGAR-A-PEPPLER, COCKEY'SVILLE	
Address		Address		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage			
443X		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		Hypertensive arterio-sclerotic vascular disease	
{		DUE TO		? yrs.	
{		(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/12/57, 19, to 7/14/57, 19, that I last saw the deceased alive on 7/14/57, 19, and that death occurred at 4:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edwin B. Jarrett</i> PHYSICIAN'S NAME (Type) Edwin B. Jarrett, M.D.		ADDRESS (Street, city or town, state) 11 East Chase St., Baltimore-2, Md.		ADDRESS (Street, city or town, state) 7/15/57 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 16/57		22c. NAME OF CEMETERY OR CREMATORIUM YES SCP M.E.	
23. FUNERAL DIRECTOR'S SIGNATURE W. COOK-TOWSON INC. TOWSON - MD.		ADDRESS		22d. LOCATION (City, town, or county) COCKEY'SVILLE, MD.	
VS A15 (4) 15M 9/55		24a REC'D BY REGISTRAR DATE JULY 18 1957		24b. REGISTRAR'S SIGNATURE <i>W. Cook</i>	

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BUREAU N.Y.

07218  
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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b <b>3 WKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		d. STREET ADDRESS <b>355 EUDOWOOD DRIVE</b> e. IS RESIDENCE ON A FARM? <b>355 EUDOWOOD LANE</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)							
3. NAME OF (Type or print) <b>DARLENE</b>		First	Middle	Last	4. DATE OF DEATH <b>JULY 21 1957</b>		
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-1-57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>JOSEPH HUSEN</b>				<b>MD.</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYDROCEPHALUS</b> INTERVAL BETWEEN 752X      ONSET AND DEATH <b>3 WKS.</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.      (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)      (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>William A. Pillson</i>		DATE SIGNED <i>7/21/57</i>					
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSON</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Stephenson</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Hartman - 1201 M. Cullis St.</i>		ADDRESS <i>XV Calle, M.D.</i>		24a. REC'D BY REGISTRAR <b>DATE 25 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Patel Hayes</i>	
VS. AT 15(MS) 5M 9/55							

BUREAU X. 61

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REGELIVE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07219

Reg. Dist. No.

(7236)

1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb <b>5yr1mth16days</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>							
f. STREET ADDRESS <b>1 N. Meadow Rd. 115 Meadow Road</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>FLoyd</b>	Middle <b>Louis</b>	Last <b>Porstmann Sr.</b>	4. DATE OF DEATH <b>July 18 1957</b>	Month <b>July</b>	Day <b>18</b>	Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1898</b>	9. AGE (in years last birthday) <b>58 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>				11. BIRTHPLACE (State or foreign country) <b>Iowa</b>			
13. FATHER'S NAME <b>Julius V. Porstmann</b>				14. MOTHER'S MAIDEN NAME <b>Nettie May Meyers</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>unknown</b>				17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>				INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(a) DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last.				(b) DUE TO <b>Asphyxia</b>							
(c) DUE TO <b>Foreign body in bronchus (ingested food)</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				20. WAS EXTERNAL CAUSE PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>strangled while eating dinner</b>				20c. TIME OF INJURY Month, Day, Year Hour <b>July 18 1957</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, off-cabildge, etc.) <b>Hospital</b>				20f. (City or town) <b>Catonsville</b>			
20g. (County) <b>Baltimore</b>				20h. (State) <b>Md.</b>				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. M. Kieffer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>July 19, 1957</b>			
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/22/57</b>			
22c. NAME OF CEMETERY OR CREMATORIUM <b>Glen Haven Cemetery</b>				22d. LOCATION (City, town, or county) <b>Glen Burnie, Md.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCullough Funeral Home</b>				ADDRESS <b>1001 E. Pratt Street, Baltimore, MD.</b>				24a. REC'D BY REGISTRAR <b>JUL 22 1957</b>			
VS. ATMS(S) SM 9/55				24b. REGISTRAR'S SIGNATURE <b>Ollie French</b>							

RECEIVED  
BUREAU V. 8

JUL 22 1967

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07220

(7237)

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Baltimore</i>		MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chase</i>		c. LENGTH OF STAY IN 1b <i>Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ebenezer Rd.</i>		e. STREET ADDRESS <i>Ebenezer Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Clinton</i>		First <i>A.</i>	Middle <i>Porter</i>
4. DATE OF DEATH Month <i>July</i>		Day <i>29</i>	Year <i>1957</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 30, 1877</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Builder - Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto., Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Porter</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Collins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Dorothy Porter</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Carcinoma Prostate, c metastases</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs. -</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Balto.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 25, 1957</i> , to <i>July 29, 1957</i> , that I last saw the deceased alive on <i>July 29, 1957</i> , and that death occurred at <i>11:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>ADDRESS</i> DATE SIGNED <i>DATE SIGNED</i>			
ACTUAL SIGNATURE <i>Time E. Grissner</i> M.D.			
PHYSICIAN'S NAME (Type)			

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 1, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Orem's Methodist</i>		22d. LOCATION (City, town, or county) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>LaSalle Funeral Home</i>		ADDRESS <i>7401 Belair Rd.</i>		24a. REC'D BY REGISTRAR <i>DATE 11 31 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Hurley</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DUPEAU V. S.

-- 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07221  
44

07238

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rheem Manufacturing Co.		d. STREET ADDRESS 6937 Conley Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elwood	Middle Price	Last July 18 1957
4. DATE OF DEATH	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 29, 1916
9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Keeper		10b. KIND OF BUSINESS OR INDUSTRY Rheem Manufacturing	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Price		14. MOTHER'S MAIDEN NAME Elsie Collett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 189-05-1649	
17. INFORMANT Mr. Dorothy Price		Address 6937 Conley Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Coronary Occlusion with Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 3 mos. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1957, to July 18, 1957, that I last saw the deceased alive on July 18, 1957, and that death occurred at 3:15 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE John E. Grismer M.D. ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.		24a. REC'D BY REGISTRAR DATE JUL 23 1957	
		24b. REGISTRAR'S SIGNATURE Lester L. Hartley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 23 1970

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07239

## CERTIFICATE OF DEATH

07222  
144

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>30 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF (Type or print) <b>WILLIAM</b>		First <b>E.</b>	Middle <b>QUEEN</b>
4. DATE OF DEATH <b>July 3 1957</b>		Month <b>July</b>	Day <b>3</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>March 20, 1923</b>		9. AGE (In years from birthday) <b>34 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. IF UNDER 24 HRS. Days <b>0</b>	13. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Greaser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>	14. MOTHER'S MAIDEN NAME <b>Goldie Gray</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-22-0538</b>	17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</b> <b>442X</b>		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____		DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>OBESITY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>VA</b>	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VA</b>
21. I certify that attended the deceased from June 3, 1957, to July 3, 1957, at <b>VA</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Elroy O. Wilson Funeral Home, 2004 Orleans, Baltimore, Maryland</b>		DATE SIGNED <b>7/3/57</b>	
ACTUAL SIGNATURE <i>Irving Freeman</i>		M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND 7/3/57</b>	
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 8, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson Funeral Home, 2004 Orleans, Baltimore, Maryland</b>		24a. ADDRESS <b>JUL 5 1957</b>	
		24b. REG'D BY REGISTRAR <b>J. Dawson L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07240

## CERTIFICATE OF DEATH

07223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland	b. COUNTY	Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Catonsville		2mths 3dys		Waldorf, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				
				Waldorf, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. SPRING GROVE STATE HOSPITAL								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
William		Robert		Rawlings	July	5	19	57
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
male	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 26, 1884	73 yrs.	Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
farmer				Maryland		U. S. A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Benjamin Franklin				? DeVaughn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
unknown		unknown		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH								
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) Gangrene left foot								
lying cause last. (c)								
DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 24, 1957, to July 5, 1957, that I last saw the deceased alive on July 5, 1957, and that death occurred at 12:10 AM, from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE Stella Wachsler, M.D. SPRING GROVE STATE HOSPITAL 7-5-57								
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. CATONSVILLE 28, MARYLAND								
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
Burial		July 8, 1957		Brookfield Methodist		Navy Cr. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
The Huitt Funeral Home, Waldorf, Md.				DATE JUL 9 '57		A. L. Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it can be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-2 should be filed with the registrar prior to removal, on any event within 72 hours after death.

BUREAU V. S.

JUL 6 1970

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7241)

## CERTIFICATE OF DEATH

07224  
334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>55 Yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Woodlawn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2118 Lorraine Park Ave.</b>				d. STREET ADDRESS <b>2118 Lorraine Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank L. Hale</b>		First	Middle	Last	4. DATE OF DEATH <b>Reed</b>	Month	Day	Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 30, 1881</b>	9. AGE (In years last birthday) <b>75 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Samuel A. Reed</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Younger</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-19674</b>		17. INFORMANT <b>Mrs. Eva L. Reed 2118 Lorraine Ave.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carries-vascular Acc.</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) <b>Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. 1410 Wmso's Mill Rd.</b>		20f. (City or town) (County) <b>Baltimore</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>6/20</b> , 19 <b>57</b> , to <b>7/11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7/9</b> , 19 <b>57</b> , and that death occurred at <b>10 p.m.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Milton Schlenoff</b> PHYSICIAN'S NAME (Type) <b>Milton Schlenoff MD</b>						ADDRESS (Street, city or town, state) <b>1410 Wmso's Mill Rd.</b>		DATE SIGNED <b>7/11/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-13-1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong 3rd 110 W. North Ave.</b>		ADDRESS <b>JUL 15 1957</b>		24a. REC'D BY REGISTRAR <b>Dr. Jim Martin</b>		24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

July 15 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07242

## CERTIFICATE OF DEATH

07225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>Baltimore</i> MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>Catonsville</i>		<i>Baltimore</i>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>2 years</i>		<i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Elm Ridge Nursing Home</i>		<i>5502 Rembrake Ave.</i>	
e. IS RESIDENCE ON A FARM?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>COYA</i>	<i>Elizabeth</i>	<i>Reynolds</i>	<i>July</i>
4. DATE OF DEATH	Month	Year	
<i>July</i>	<i>1957</i>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>W.</i>	<i>W.</i>	<i>March 10, 1876</i>	9. AGE (In years last birthday) <i>81 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Housewife</i>		<i>Home</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Nathan Stymiller</i>		<i>Elizabeth A. Warner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>None</i>	
17. INFORMANT		Address	
<i>Mr. James Shira</i>		<i>5502 Rembrake Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO <i>massive Cerebral Hemorrhage</i> 24 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO <i>Vascular erosion</i> 24 hrs.			
C. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Rheumaloid arthritis Severe &amp; Debilitating</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>ADDRESS (Street, city or town, state)</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
<i>April 1957</i>		<i>4605 Edmondson Ave</i>	
21. I certify that I attended the deceased from <i>April</i> , 1957, to <i>July 6, 1957</i> , that I last saw the deceased alive on <i>July 1, 1957</i> , and that death occurred at <i>11:15 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		<i>Cliff Coffey Jr. M.D.</i>	
PHYSICIAN'S NAME (Type)		<i>4605 Edmondson Ave</i>	
22b. BURIAL, CREMATION, REMOVAL (Specify)		22c. DATE THEREOF	
<i>Burial</i>		<i>7-10-57</i>	
22e. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<i>Graveside</i>		<i>Glenwood, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D. BY REGISTRAR / 24b. REGISTRAR'S SIGNATURE	
<i>Kathleen A. Haught - Glenwood, Md.</i>		<i>Over 50 years</i>	
		DATE	

PURCHASED BY

JUL 12 1957



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 07243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	c. LENGTH OF STAY IN lb <b>30 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>14 E. Overlea Ave.</b>		d. STREET ADDRESS <b>14 E. Overlea Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Gustave H. Rippert</b>	First	Middle	Last
4. DATE OF DEATH <b>July 21, 1957</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1896</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pay Master</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown Rippert</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Ficken</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. # 1</b>		16. SOCIAL SECURITY NO. <b>212-09-8169</b>	17. INFORMANT <b>Mrs. Lois L. Rippert</b>
		Address <b>14 E. Overlea Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>approx 2 hrs.</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) <b>Atherosclerotic Cardiovascular Dis. undet.</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John C. Hyde</i>	DATE SIGNED <i>7-23-57</i>		
EXAMINER'S NAME (Type) <b>JOHN C. HYDE</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 27, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Greenwood</b>	22d. LOCATION (City, town, or county) (State) <b>New Orleans, La.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>LaSalle Funeral Home</i>	ADDRESS <b>7401 Belair Rd.</b>	24a. REC'D BY REGISTRAR <b>JUL 23 1957</b>	24b. REGISTRAR'S SIGNATURE <i>Mrs. D.L. Perfandy</i>

BUREAU V. S.

TL 9 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07244

## CERTIFICATE OF DEATH

17227

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Md. b. COUNTY Baltgo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b 52 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Powers Avenue	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ada Estelle	Middle	Last Roberts
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E Francis		14. MOTHER'S MAIDEN NAME Mary Ann Tombit	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Lawrence Roberts-Cockeysville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH immediately	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost		(b) Atherosclerotic cardio-vascular disease 10 yrs.	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 40 d. i.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 to July 1957, that I last saw the deceased alive on July 27, 1957, and that death occurred at 8 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Elizabeth B. Sherrill M.D. ADDRESS (Street, city or town, state) Cockeysville, Maryland PHYSICIAN'S NAME (Type) Elizabeth B. Sherrill DATE SIGNED July 27, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Providence Methodist Cem.		22d. LOCATION (City, town, or county) Providence, Balto. Co., Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		24a. ADDRESS ADDRESS Towson, Md.	
24b. REC'D BY REGISTRAR DATE 1957		24c. REGISTRAR'S SIGNATURE D. Beale	

REAU V. S.

MUG 2

SEAL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07228

07245

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN lb <b>1mth28days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
3. NAME OF DECEASED (Type or print) <b>Mary</b>			First <b>Mary</b>	Middle <b>Christina</b>	Last <b>Robinson</b>
4. DATE OF DEATH <b>July 22</b>			Month <b>July</b>	Day <b>22</b>	Year <b>19 57</b>
5. SEX <b>female</b>			6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1868</b>
9. AGE (In years lost birthday) <b>89</b>			10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		
10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Frederick W. Lammers</b>			14. MOTHER'S MAIDEN NAME <b>Mary Christina Hoffmann</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO <b>unknown</b>		
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <b>Arteriosclerosis, generalized and severe</b> (c)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>450.0</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Catonsville</b> (County) <b>Md.</b> (State)		
21. I certify that I attended the deceased from <b>May 24</b> , 1957, to <b>July 22</b> , 1957, that I last saw the deceased alive on <b>July 22</b> , 1957, and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Stella Wachsler</b> M.D. <b>SPRING GROVE STATE HOSPITAL 7-22-57</b> DATE SIGNED					
ACTUAL SIGNATURE <b>Stella Wachsler</b>			PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>7-24-1957</b>		
22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn</b>			22d. LOCATION (City, town, or county) <b>Baltimore Co. Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong 3077 Webster Ave.</b>			24a. REC'D BY REGISTRAR DATE JUL 24 57		
			REGISTRAR'S SIGNATURE <b>Aut. Leach</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V.

JUL 24 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07246

## CERTIFICATE OF DEATH

0722944

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>44 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2618 Shirley Avenue, Baltimore</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2618 Shirley Avenue</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>ISADORE</b>	Middle <b>JAKE</b>	(Also: ROBINSON)	4. DATE OF DEATH <b>July 17 1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1896</b>	9. AGE (In years last birthday) <b>61</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman- Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	11. BIRTHPLACE (State or foreign country) <b>Winston Salem, N.C. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Eli Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Jennie MN: Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF BRONCHUS OF UPPER LOBE OF</b> <b>RIGHT LUNG</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>VA</b>	Month <b>19</b>	Day <b>19</b>	Year <b>1957</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	(County) <b>MD</b>	(State) <b>MD</b>
21. I certify that <input checked="" type="checkbox"/> attended the deceased from <b>June 3 1957</b> to <b>July 17 1957</b> <input checked="" type="checkbox"/> and death occurred at <b>10:28 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/17/57</b>								
ACTUAL SIGNATURE <i>Irving Freeman</i> PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief Medical Service</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-19-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Other Sholom</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis, Inc., 2100 Eutaw Place, Baltimore, Md.</b>	ADDRESS	24a. REC'D BY REG. OFFICE <b>19 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Donald L. Parker</i>				

S. A. O'NEILL

100

PEANUTS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07247

## CERTIFICATE OF DEATH

0723038

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>6 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1001 West Joppa Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>SISTER MARY RODRIGUEZ (Catherine Gillespie)</b>	Middle	Last 4. DATE OF DEATH <b>July 15, 1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>November , 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		9. AGE (in years last birthday) <b>80 yrs</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Convent</b>		10. BIRTHPLACE (State or foreign country) <b>Ballinascreen, Ireland</b>	
11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		12. MOTHER'S MAIDEN NAME <b>Eliza Barnett</b>	
13. FATHER'S NAME <b>Thomas Gillespie</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Convent Records, 1001 W. Joppa Road, Towson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thyrinosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b>	
442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <b>Hypertensive Cardiac-Renal 10 yrs</b>		(c) <b>Vascular Disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1, 1940</b> to <b>July 16, 1957</b> that I last saw the deceased alive on <b>July 10, 1957</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		DATE SIGNED <b>7/16/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>		7501 York Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 18, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Convent Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>1001 W. Joppa Rd. Towson, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Vernon Lammie</b>		ADDRESS 4611 Pk. Hgts. Balto. Md. DATE JUL 18 1957	
		24a. READ BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <b>Mabel Hayes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 18 1957

BUREAU N.Y.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07248

## CERTIFICATE OF DEATH

07231  
38

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the physician prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>BALTO</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>		c. LENGTH OF STAY IN 1b <b>ARMACOST NURSING HOME REGESTER AVE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d. STREET ADDRESS <b>4305 MARBLE HALL ROAD</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>ARMACOST NURSING HOME REGESTER AVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>HENRY A ROHMER</b>		First	Middle	Last	4. DATE OF DEATH <b>JULY 21, 1957</b>	Month	Day	Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1900</b>	9. AGE (In years (last birthday) <b>56</b> yrs.)	IF UNDER 1 YEAR Months <b>56</b>	IF UNDER 24 HRS Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Liquor</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>PETER A ROHMER</b>		14. MOTHER'S MAIDEN NAME <b>BABETTE LEDERER</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. DOROTHY E ROHMER</b>		Address <b>4305 Marble Hall Road</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRRHOSIS OF LIVER</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs.</b>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stealing the under- lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work* <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)      (County)      (State)		
21. I certify that I attended the deceased from <b>5-20-</b> , 19 <b>50</b> to <b>JULY 21, 1957</b> that I last saw the deceased alive on <b>JULY 20, 1957</b> and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>1532 HAYENWOOD RD.</b>		
ACTUAL SIGNATURE <b>Arthur K. Regan, M.D.</b>						DATE SIGNED <b>1532 HAYENWOOD RD.</b>		
PHYSICIAN'S NAME (Type) <b>ARTHUR K. REGAN</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Park</b>		22d. LOCATION (City, town, or county) <b>Balto Md.</b>		(State)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Park</b>		22d. LOCATION (City, town, or county) <b>Balto Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook Inc.</b>		ADDRESS <b>127 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>111 23 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>		

RECEIVED  
MURRAY V. S.

LL 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

67  
C7249

## CERTIFICATE OF DEATH

072332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Parkville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7834 Wendover Ave		d. STREET ADDRESS 1 7834 Wendover Ave	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alessandro	First	Middle	Last Rosellini	
4. DATE OF DEATH July	Month	Day	Year 29 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 13, 1889	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? Italy				
13. FATHER'S NAME Niccola Rosellini		14. MOTHER'S MAIDEN NAME Zelinda Gabani		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-07-7876 Mrs. Josephine Rosellini		
17. INFORMANT		Address 7834 Wendover Ave		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X <i>Gastric carcinoma Stomach with generalized metastasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized metastasis</i> DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH 19 mos.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 15, 1956, to July 29, 1957</i> , that I last saw the deceased alive on <i>7/13, 1957</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>7101 Harford Rd.</i> DATE SIGNED <i>7/30/57</i>
ACTUAL SIGNATURE <i>Nathan J. Ruck</i>	PHYSICIAN'S NAME (Type) <i>Nathan J. Ruck</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug. 1, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Lorraine Park</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>5305 Harford Rd.</i>	24a. REC'D BY REGISTRAR DATE <i>11/1/57</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. L. M. Bacon</i>

RECEIVE

JUL 31 1957

BUREAU V.

may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 page 3 will be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical examiner, Dr. DD Caples advised Dr. Williams to sign.  
 Patient was seen by Dr. Paul Royse on July 20, day of death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07250

## CERTIFICATE OF DEATH

07233

Reg. Dist. No. 31

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Robb Nursing Home - 4105 Essex Rd.</b>						d. STREET ADDRESS <b>732 Milford Mill Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>CATHERINE</b>			First <b>CATHERINE</b>	Middle <b>AUGUSTA</b>	Last <b>ROWLES</b>	4. DATE OF DEATH <b>Aug. 14, 1887</b>	Month <b>July</b>	Day <b>20</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1887</b>			9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>9</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>			11. BIRTHPLACE (State or foreign country) <b>Md.</b>			12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Julius F. Scriba</b>			14. MOTHER'S MAIDEN NAME <b>Mary R. Douglass</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO <b>no</b>			17. INFORMANT <b>Mr. Charles D. Rowles - 732 Milford Mill Rd.</b>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>									INTERVAL BETWEEN ONSET AND DEATH
332 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis									
(c) DUE TO Diabetes Mellitus, abscess buttock									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 21a X <b>Diabetes Mellitus, abscess buttock</b>									19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> 20d. INJURY OCCURRED p. m.                    While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) <b>Baltimore</b> (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>Feb. 9, 1949</b> , to <b>July 18, 1957</b> , that I last saw the deceased alive on <b>July 18, 1957</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1632 Reisterstown Rd., Pikesville, Md.</b>									DATE SIGNED <b>22 July 1957</b>
ACTUAL SIGNATURE <b>Charles H. Williams</b>			22b. DATE THEREOF <b>July 20, 1957</b>			22c. LOCATION (City, town, or county) <b>Baltimore, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Charles H. Williams, M.D.</b>			22d. BURIAL, CREMATION, REMOVAL (Specify) <b>No</b>			22e. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cem.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Pickering &amp; Sons - Baltimore, Md.</b>			23b. ADDRESS <b>1632 Reisterstown Rd., Pikesville, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>7/23/57</b>			24b. REGISTRAR'S SIGNATURE <b>Dr. Wm. S. Martin</b>

BUREAU A. S.

JUL 24 1977

REGELVÉ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07251

## CERTIFICATE OF DEATH

07234

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN lb

30 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Veterans Administration Hospital

3. NAME OF  
DECEASED  
(Type or print)First  
ARCHIEMiddle  
D.Last  
RULE4. DATE  
OF  
DEATH

July

14

Year  
19 57

## 5. SEX

MALE

## 6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

9/7/97

9. AGE (In years  
from birthday)59  
yrs.10. IF UNDER 1 YEAR  
Months DaysIF UNDER 24 HRS  
Hours Min10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Pressman

## 10b. KIND OF BUSINESS OR INDUSTRY

Publishing House

## 11. BIRTHPLACE (State or foreign country)

Virginia

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

William P. Rule

## 14. MOTHER'S MAIDEN NAME

Martha Fielder

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Yes

(If yes, give war or dates of service)

WWI

## 16. SOCIAL SECURITY NO.

237-14-5270

## 17. INFORMANT

Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION

INTERVAL BETWEEN  
ONSET AND DEATH  
FEW MINUTES

420.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause first.

(b)

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

3 YEARS

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

## 20c. TIME OF INJURY

Month

Day

Year

Hour

o. m.

19

p. m.

## 20d. INJURY OCCURRED

While Not while  
of work  of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 14, 19 57, to July 14, 19 57, and that death occurred at 10:00 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Irving Freeman, M.D. Veterans Administration Hospital

7/15/57

PHYSICIAN'S  
NAME (Type)

IRVING FREEMAN, M.D. Chief, Medical Fort Howard, Maryland

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

7-15-57

## 22b. DATE THEREOF

Oakdale Cemetery

## 22d. LOCATION (City, town, or county)

Mt. Airy, N. Carolina

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

John Cook Blight, Jr.

## ADDRESS

John Cook Blight, Inc. 6009 Harford Rd., Baltimore 14, Md.

## 24a. REC'D BY REGISTRAR

DATE 7/18/57

7/18/57

## 24b. REGISTRAR'S SIGNATURE

Hanson L. Farley

SUNDEAU V. S

70

McGraw-Hill

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07252

## CERTIFICATE OF DEATH

07235  
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge</b>		c. LENGTH OF STAY IN 1b <b>107 Branden Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>107 Branden Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Margaret</b>	Middle <b>Miller</b>	Last <b>Samuels</b>
4. DATE OF DEATH	Month <b>July</b>	Day <b>5</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19, 1913</b>
9. AGE (In years lost birthday) <b>43</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
13. CITIZEN OF WHAT COUNTRY: <b>Mo.</b>	14. FATHER'S NAME <b>H. Sinclair Miller</b>		
15. MOTHER'S MAIDEN NAME <b>Anne Ruwart</b>	16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		
17. SOCIAL SECURITY NO.	18. INFORMANT <b>John B. Miller 7222 Linark Road</b>	Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> DUE TO 155X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Metastasis from</b> (b) <b>Carcinoma of colon</b> DUE TO 155X (c) <b>?</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>47</b> , to <b>July 5, 1957</b> , that I last saw the deceased alive on <b>7-5-1957</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>D. E. Russell, M.D.</b> PHYSICIAN'S NAME (Type) <b>Thomas E. Russell, Jr., M.D.</b>	ADDRESS (Street, city or town, state) <b>3901 N. Charles St.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 8, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>New Cathedral</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Pl.</b>	24a. ADDRESS <b>15M 9755</b>	24b. REC'D BY REGISTRAR <b>JUL 10 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mabel Bryan</b>

BUREAU V. A.

JUL 10 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07236

07130

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE	Maryland		
Dundalk				b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		7147 Holabird Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First William	Middle Percy	Last Samuels	4. DATE OF DEATH July 17 1957		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	October 25, 1898			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Burner		Bethlehem Steel		Middletown, Indiana		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
William H. Samuels		Anne Leichen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
WW I		232-20-2214		William H. Samuels, 6102 Fortview Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Carcinoma of Stomach				INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO					
151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.							
{ (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1957, to July 1957, that I last saw the deceased alive on 13 July 1957, and that death occurred at M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>B.W. Sollod</i>		M.D. 2903 DUNRAN RD 7-1957				DATE SIGNED 7-1957	
PHYSICIAN'S NAME (Type) B.W. SOLLOD, M.D.		Dundalk - 22-7mf					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS				24a. REC'D. BY REGISTRAR DATE 22 JUN 1957	24b. REGISTRAR'S SIGNATURE <i>John Kelley</i>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGEAU V. S.

JUL 22 1957

REGEAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07237

38

C7253

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN 1b <i>x2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7801 Oak Avenue</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>1 7801 Oak Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Eva Estelle Schafer</i>		4. DATE OF DEATH <i>July 7th</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 8, 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Friez Instruments</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
13. FATHER'S NAME <i>Charles Pool</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie Henry</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. Harry J. Schafer, Sr. 7801 Oak Avenue</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>175X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Adenocarcinoma of rectum with metastasis 8 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>K. Elliott Harris</i>	M.D.	8100 Harford Road #14 7/8/57	
PHYSICIAN'S NAME (Type) <i>S. Elliott Harris</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/10/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>	ADDRESS <i>5305 Harford Road #14</i>	24a. REC'D BY REGISTRAR DATE <i>11 17 1057</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. H. M. Beatty</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECIEVED  
BUREAU V. S.

UL 10 1952

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07131

## CERTIFICATE OF DEATH

0723841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b		d. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 S. Dundalk Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		f. STREET ADDRESS 60 S. Dundalk Ave.	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROSINE SCHLAILE		First	Middle	Last	4. DATE OF DEATH July 16, 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> April 1, 1872	8. AGE (In years last birthday) 85 yrs.	9. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Ludwig Friz		14. MOTHER'S MAIDEN NAME Fredericka ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO		17. INFORMANT Mr. Bertha Colly 60 S. Dundalk Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  (b) DUE TO  (c)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
		Cerebral Arteriosclerosis		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1948, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at 11 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED M.D. 2900 Remond Rd 7-18-57	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) B.W. SOLLOD, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		ADDRESS		24a. REC'D BY REGISTRAR DATE 19 105	
				24b. REGISTRAR'S SIGNATURE J. Kelly	

BUREAU V.

ML 52 1957

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1723  
38

## 07254 CERTIFICATE OF DEATH

Reg. Dist. No.

The

THIS IS A PERMANENT RECORD. OR WANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

PLEASE TYPE, OR WANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of information may be supplied. Physicians: please write the causes of death clearly and legibly.  
THIS CERTIFICATE MUST BE FILED IN THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DEATH.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Howard Scheff		7-10-57	
3. PLACE OF DEATH A Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Baltimore City, Maryland		A. STATE	B. COUNTY
50705 Stoneleigh Rd., Baltimore		N.D.	BALTO.
c. LENGTH OF STAY IN BALTIMORE		Yrs. Mo. Days	C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
M	W		STONELEIGH-Baltimore 12
5. SEX		6. COLOR OR RACE	
M		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	
Retired		M	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Retired		Building Contractor	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Scheff		Barbara Kahl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give rank or dates of service)		16. SOCIAL SECURITY NO.	
Yes - 1918 Army		216-01-3432	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		17. INFORMANT ADDRESS	
Coronary Thrombosis, recurrent		July 8, 1957, Mrs. Jacqueline Scheff, Same	
CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH few minutes	
Coronary Thrombosis, recurrent		Anterior occlusive cardiovascular disease since 1955	
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
422.1			
MEDECIN			
21D. TIME (Month) (Day), (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
July 1957		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1957, that (I) (we) last saw the deceased alive on July 8, 1957, and that death occurred at 10:30 A.M., from the causes and on the date stated above.		July 8, 1957 to 1957.	
23A. SIGNATURE		23B. ADDRESS	
Robert E. Gruber		79 Michigan Ave., Towson 4 7-10-57	
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		7-13-57	
24C. NAME OF CEMETERY OR CREMATORIUM		24D. LOCATION (City, town, or county) (State)	
Oak Lawn Cemetery		Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
7-12-57		Mable C. Gray	
VS 150		25 FUNERAL DIRECTOR	
		Leonard J. Luck 5305 Harford	
		ADDRESS	
REGISTRAR			

BUREAU V. S

JUL 16 1957

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bolt copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

07255

**CERTIFICATE OF DEATH**

Reg. Dist. No. 40

**1. PLACE OF DEATH**

COUNTY BALTIMORE  
 CITY (If outside corporate limits, write RURAL  
OR  
end give nearest town)  
 TOWN COWENTON

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS  
AFFELD AVE

MARYLAND  
 LENGTH OF STAY  
(in this place)

STATE MARYLAND COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL end give nearest town)  
 OR  
 TOWN COWENTON  
 STREET  
ADDRESS  
AFFELD AVE  
 (If rural give location)

**3. NAME OF  
DECEASED  
(Type or Print)**Lewis

(Middle)

(Last)

Schultz**5. SEX**M**6. COLOR OR  
RACE**W**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)****8. DATE OF BIRTH**MarriedJuly 22, 1875**9. AGE last birthday**82 yrs.**10. IF UNDER 1 YEAR****11. IF UNDER 24 HRS.**

Months

Days

Hours

Min.

**10a. USUAL OCCUPATION** (Give kind of work  
done during most of working life, even if  
retired)LABORER**10b. KIND OF BUSINESS  
OR INDUSTRY**FARM**11. BIRTHPLACE** (State or foreign country)MARYLAND**12. CITIZEN OF WHAT  
COUNTRY?**U.S.A.**13. FATHER'S NAME**ANTONE SCHULTZ**14. MOTHER'S MAIDEN NAME**UNKNOWN**15. WAS DECEASED EVER IN U. S. ARMED FORCES?**No**16. SOCIAL SECURITY NO.**410**17. INFORMANT & ADDRESS**219-05-0524HARRY SCHULTZ 3008 Peyton Ave.INTERVAL BETWEEN  
ONSET AND DEATH**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH****4. IMMEDIATE CAUSE**

(A)

Arterosclerotic Cardiovascular Disease**ANTECEDENT CAUSE(S) DUE TO****DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE****STATING UNDERLYING CAUSE LAST, DUE TO**

(C)

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**longstanding heart failure**19a. DATE OF OPERATION**5/34/1**19b. MAJOR FINDINGS OF OPERATION**

20 AUTOPSY?

YES

NO

**21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)****21c. WHERE DID INJURY OCCUR? (City or town)**

(County)

(State)

**21d. TIME OF INJURY (Month) (Day) (Year) (Hour)****21e. INJURY OCCURRED****21f. HOW DID INJURY OCCUR?**

M.    White    Not white

at work    at work

**22. I hereby certify that I attended the deceased from**July 22, 1955, to July 25, 1957,alive on July 23, 1957, and that death occurred at 12 P.M. from the causes and on the date stated above.SIGNATURE William A. Tyson M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED 7-25-57**23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)****DATE THEREOF****NAME OF CEMETERY OR CREMATORIUM****LOCATION (City, town, or county)**

(State)

Burial7-27-57FORK METHODIST CHURCHMARYLAND**24. REC'D BY REGISTRAR****REGISTRAR'S SIGNATURE****25. FUNERAL DIRECTOR'S SIGNATURE**

ADDRESS

Dr Walter Howard Kim Coop Blight Jr.6009 Hayford Rd.DATE 7/29/57

BUREAU V. 2

JUL 26 1967

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07256  
38

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Baltimore</i> MARYLAND		<i>Maryland</i> Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Rodgers Forge 4 yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <i>Rodgers Forge Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>240 Rodgers Forge Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>SAMUEL JOSEPH SHAMBERGER</i>		First <i>SAMUEL</i>	Middle <i>JOSEPH</i>
4. DATE OF DEATH	Month <i>July</i>	Day <i>2</i>	Year <i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 20, 1896</i>
male	white		9. AGE (in years from birthday) <i>61 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Roofing Business</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Daniel Shambarger</i>		14. MOTHER'S MAIDEN NAME <i>Martha J.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mr. C. Edwin Fitzell - 3342 Gilman Terrace</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>Cerebral Hemorrhage</i> <span style="float: right;">Sudden</span>		INTERVAL BETWEEN ONSET AND DEATH <i>450.0</i>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <i>Generalized arteriosclerosis</i> <span style="float: right;">10 yrs.</span>		(b)  DUE TO  <i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>450.0</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) <span style="float: right;">(State)</span>
20g. CHIEF MEDICAL EXAMINER M.D. <i>Charles F.O'Donnell</i>		20h. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE  <i>Charles F.O'Donnell</i>		DATE SIGNED  <i>7/3/57</i>	
EXAMINER'S NAME (Type) <i>Charles F.O'Donnell</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/5/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Woodlawn Cemetery</i>		22d. LOCATION (City, town, or county)  <i>Woodlawn, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE  <i>John J. Wicker &amp; Sons - Baltimore</i>		24a. REG'D BY REGISTRAR DATE <i>JUL 5 1957</i>	
ADDRESS <i>1100 E. 36th Street</i>		24b. REGISTRAR'S SIGNATURE  <i>Merle Gray</i>	

SUKHDEV V.

SEKHPUR

07243

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
C7257 Baltimore		Catonsville		29yr5mth14days		X Baltimore City			
MARYLAND						Baltimore City Hospital			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Mollie				Sheckells	July 23			19 57	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years by birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.			
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	unknown		74 <sup>2</sup> yrs	Months	Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
dressmaker				Maryland		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address					
Charles R. Sheckells		Jane Minnifree							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  no		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH			
		unknown		Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		DUE TO		fracture of skull due to a fall accident			
900.7		Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause first.		(b) DUE TO					
				(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pt. was pushed by another patient causing her to fall down steps with resulting injury of head.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour 6:20 AM 7-23-57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) hospital		20f. (City or town) Catonsville	(County) 28, Md.	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED July 23, 57							
ACTUAL SIGNATURE  George M. Kieffer, M.D.		EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION OR REMOVAL (Specify) burial		22b. DATE THEREOF 8-2-57		22c. NAME OF CEMETERY OR CREMATORIUM SPRING GROVE STATE HOSP.		22d. LOCATION (City, town, or county) Catonsville 28, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE  SRING GROVE STATE HOSPITAL		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 6 '57		24b. REGISTRAR'S SIGNATURE Albert			

3. V. S.  
LAWRENCE

## MARGIN RESERVED FOR BONDING

PLEASE WRITE PLAINLY, WITH UNFADING INK.  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

07244  
3

07258

2411 N. Charles Street, Baltimore

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

Item 2 Filed 7/18 6-15 '57 et

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
<i>Baltimore</i>		<i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<i>Catonsville</i>		<i>Baltimore City</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS AL+		
<i>6 Fulton Avenue</i>	<i>1111 Fulton Avenue, Bldg. A, Baltimore Place, Baltimore St.</i>		
70. 3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Solomon</i>		<i>(Month) (Day) (Year)</i>	
(First)	(Middle)	(Last)	<i>July 25 1957</i>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>1901</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Tailor</i>		<i>Baltimore, Md.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>late Samuel Shuster</i>		<i>Lena Stetby</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<i>William Applefeld - 3805 Holton Rd</i>	
17. INFORMANT AND ADDRESS			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) ...</p> <p>Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</p> <p>(c) ...</p>			
INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<i>June 1957</i>		<i>Carcinoma bowel with metastases</i>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
(Specify)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 18, 1957</i> , to <i>July 25, 1957</i> , that I last saw the deceased alive on <i>July 18, 1957</i> and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above. SIGNATURE: <i>Henry De Rosenthal, M.D.</i> ADDRESS: <i>5533 Park Hts. Ave</i> DATE SIGNED: <i>7-25-57</i>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
<i>Burial</i>		<i>July 26, 1957</i>	
NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
<i>Beth Tfiloh</i>		<i>Woodlawn, Md.</i>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
<i>7/26/57</i>		<i>J. A. Hecht</i>	
24. FUNERAL DIRECTOR		ADDRESS	
<i>Sal Levinson &amp; Sons</i>		<i>1124-26 W. North Ave</i>	

BUREAU V. S

JUL 09 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07245  
43

Reg. Dist. No.

07259

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
BALTIMORE				a. STATE	b. COUNTY
FULTON		MARYLAND		MARYLAND	BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
FULTON				DARKVILLE X2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
				8506 OARLEIGH RD	
e. IS RESIDENCE ON A FARM?				e. IS RESIDENCE ON A FARM?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
WARREN		A		SHOOK	7	-27	1957	

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	FEB 27 1931	26 yrs	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LINEMAN	TELEPHONE CO.	MARYLAND	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ALBERT H. SHOOK	VELMA CLEAVER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO		MRS ELIZABETH SHOOK 8506 OARLEIGH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE GUNSHOT WOUNDS OF 981X DUE TO HEAD		
Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last.		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour	Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CAR-STREET	20f. (City or town) BALTIMORE	(County) Mo	(State)
9 15	7-27-57					

21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>						
--	--	--	--	--	--	--

ACTUAL SIGNATURE <i>R. S. Fisher</i>	M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 7-28-57
EXAMINER'S NAME (Type) <i>R. S. Fisher</i>		

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JULY 30 1957	22c. NAME OF CEMETERY OR CREMATORIAL DARKWOOD	22d. LOCATION (City, town, or county) DARKVILLE MD
---	-----------------------------------	--	---

23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME	ADDRESS 4216 BELAIR	24a. REC'D BY REGISTRAR DATE 30 1957	24b. REGISTRAR'S SIGNATURE <i>Mrs. A. L. Kennedy</i>
--	------------------------	---	---

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y.

NOV 30 1957

REGEIVED

## 07132 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: COUNTY <u>BALTO</u> MARYLAND CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <u>BALTO - 22</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>BALTO</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTO 22 - MD</u>	
3. NAME OF DECEASED: (First) <u>FRANK</u> (Middle) <u>J.</u> (Last) <u>SLOWIK sr.</u> (Type or Print)		4. DATE OF DEATH: (Month) (Day) (Year) <u>July 10 1957</u>	
5. SEX: <u>Male</u> COLOR OR RACE: <u>WHITE</u> 6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>Jan 30 1887</u> 9. AGE last birthday: <u>70</u> yrs. <u>70</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>RETIRED PUMPING ST.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>BALTO. CITY</u> 11. BIRTHPLACE (State or foreign country): <u>BALTO MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>MICHAEL SLOWIK</u>		14. MOTHER'S MAIDEN NAME: <u>JOSEPHINE STREGOLA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>16. SOCIAL SECURITY NO.: 17. INFORMANT &amp; ADDRESS:</u> <u>BERTHA A. SLOWIK 2110 OAKLAND AVE</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <u>Cerebro Vascular accident</u> Interval Between Onset And Death Antecedent causes (s) <u>Arteriosclerotic Cardio Vascular disease</u> <u>5 yrs</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last DUE TO DUE TO (a) <u>Sudden</u> (c) <u>5 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR? from the causes and on the date stated above. ADDRESS
22. I hereby certify that I attended the deceased from <u>July 10, 1957</u> , to <u>July 10, 1957</u> , that I last saw the deceased alive on <u>July 10, 1957</u> , and that death occurred at <u>8PM</u> , from the causes and on the date stated above. SIGNATURE <u>John J. Sowik</u> (Degree or title) <u>MD</u> DATE SIGNED <u>7/11/57</u>			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <u>BURIAL July 13, 1957</u>		NAME OF CEMETERY OR CREMATORIAL <u>ST. STANISLAUS CEM.</u>	LOCATION (City, town, or county) (State) <u>DOND AHS AVE</u>
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Marie Salkowski</u> ADDRESS <u>1000 L. Kenwood Ave</u>	
		24. FUNERAL DIRECTOR ADDRESS <u>BALTO. 24 - MD.</u>	

BUREAU V. S.  
RECEIVED  
MAY 15 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07260

## CERTIFICATE OF DEATH

Reg. Dist. No.

07247

31

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Co.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hobbsville</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hobbsville</i>		d. STREET ADDRESS <i>3110 Rolling Rd.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3110 Rolling Road</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Ida</i>	Middle <i>d</i>	Last <i>Smith</i>	4. DATE OF DEATH <i>July 17</i>	Month <i>July</i>	Day <i>17</i>	Year <i>1957</i>
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>July 23, 1879</i>	9. AGE (In years last birthday) <i>77</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during now of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY/ <i>U.S.A.</i>		
13. FATHER'S NAME <i>William C. Ness</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Gibson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mr. John C. Smith - Darsay, Md.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>dehydration - debility</i>						INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO <i>malnutrition</i>								
(c) DUE TO <i>congestive heart failure</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>July 15 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Woodlawn</i>		20f. (City or town) (County) <i>Woodlawn</i>		(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>July 15, 1957</i> to <i>July 17, 1957</i> that I last saw the deceased alive on <i>July 17, 1957</i> , and that death occurred at <i>3110 Rolling Rd.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Carroll</i> PHYSICIAN'S NAME (Type)						ADDRESS (Street, city or town, state)		DATE SIGNED
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 20, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i>		22d. LOCATION (City, town, or county) <i>Woodlawn</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR <i>John T. Stansbury - 6411 Windsor Mill Rd.</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Fred Hartman</i>		22.1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07248

07261

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. The

THIS IS A PERMANENT RECORD.  
PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of information is carefully supplied. Physicians: please write the causes of death clearly and legibly  
in ink. This certificate must be with the Bureau of Vital Records within three (3) days after death.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH JULY 15, 1957	
MARIE H. SMITH		15	
3. PLACE OF DEATH A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Baltimore City, Maryland		Maryland - Baltimore City	
B. FULL NAME OF HOSPITAL OR INSTITUTION RIDGEWAY MANOR FOR AGED.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
5743 Edmondson Ave. Balto. (28) Md.		Baltimore City	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)	
LIFE		707 North Port St. (5).	
5. SEX		6. COLOR OR RACE	
Female		White	
7. SINGLE, MARRIED, W. DOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
Widowed		Jan. 29 1898	
9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
59		U.S.A.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Housewife		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Herman Schroeder		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
No		None	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Cerebral Hemorrhage</i>	
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH <i>5y.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO <i>Arteriosclerotic Cardio</i>	
		(B) DUE TO <i>Deceased Disease</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		(C) DUE TO	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
m.		21E. HOW DID INJURY OCCUR? WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22 I certify that (I) (this hospital) attended the deceased from April 12, 1953, to July 15, 1957, that (I) (we) last saw the deceased alive on July 15, 1957, and that death occurred at 12:56 A.M., from the causes and on the date stated above.		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23A. SIGNATURE		23B. ADDRESS	
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		156 N. Melton Ave.	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
BURIAL		7/18/57	
DATE RECEIVED BY LOCAL REGISTRAR		24C. NAME OF CEMETERY OR CREMATORIAL	
JUL 17 1957		OAK LAWN CEM. BALTO., MD.	
REGISTRAR'S SIGNATURE		24D. LOCATION (City, town, or county) (State)	
<i>A. J. Reddick</i>		Hartley Miller 2334 Jefferson St.	
ADDRESS			

REGGIE

READY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07262

## CERTIFICATE OF DEATH

07249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catoonsville</b>		c. LENGTH OF STAY IN 1b <b>20yr6mth4dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>824 Park Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Naomi</b>	Middle <b>Todd</b>	Last <b>Smith</b>	4. DATE OF DEATH <b>July 24</b>	Month <b>July</b>	Day <b>24</b>	Year <b>19 57</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1895</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Nathan J. Todd</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bozman</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Records: <b>SPRING GROVE STATE HOSPITAL</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <b>Hypertensive cardiovascular disease</b> (c)						INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.      0		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Catoonsville 28, Maryland</b>		20f. (City or town) <b>Catoonsville</b>		(County) <b>Montgomery</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>July 22, 1957</b> , to <b>July 24, 1957</b> , that I last saw the deceased alive on <b>July 24, 1957</b> , and that death occurred at <b>4:25PM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Catoonsville, Maryland</b>		DATE SIGNED <b>7-24-57</b>	
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D.		SPRING GROVE STATE HOS ITAL		<b>7-24-57</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>									

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 27, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cape Charles Con-</b>	22d. LOCATION (City, town, or county) <b>Cape Charles, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Singleton, Allen Beurris</b>	ADDRESS <b>100 Main Street, Cape Charles, Virginia</b>	24a. REC'D BY REGISTRAR <b>7-29-57</b>	24b. REGISTRAR'S SIGNATURE <b>John Beurris</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

JUL 30 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07263

## CERTIFICATE OF DEATH

07250

31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		BALTO	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		VA.	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		GLEN OAK	4 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HOPE WELL VA.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		AVESBURG HOME		d. STREET ADDRESS		709 E. POYTHRESS ST.	
3. NAME OF DECEASED (Type or print)		First SARAH	Middle ANN	Last SMITH	4. DATE OF DEATH	JULY 5	Year 1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
		E. W.		3/12/1884		73 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
NONE		NONE		HO. PA.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
CHAS. MCKENNA.		? KNEPP					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		CAMPFIELD Rd Percherons AVESBURG HOME	
		—					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		(1) Cerebral Hemorrhage 8 days					
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO					
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3 - 1957, to July 5 1957, that I last saw the deceased alive on July 2 - 1957, and that death occurred at 10:27 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) 4108 Liberty St. BALTO Mo. DATE SIGNED 4-6-57					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
BURIAL 7/1/57		ST. PAUL'S VIOLETVILLE		BALTO Mo.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Paul Blenman 6067 Harford Rd				DATE JULY 9 1957		Dr. Tom Masterson	

BUREAU V. S.

UL 9 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07264

07251

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>18 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>5106 Kenwood Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ELLIS</b>	Middle <b>O.</b>	Last <b>SPENCER</b>	4. DATE OF DEATH <b>July</b>	Month <b>9</b>	Day <b>19</b>	Year <b>57</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1894</b>	9. AGE (In years last birthday) <b>63</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mutual Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Race Track</b>	11. BIRTHPLACE (State or foreign country) <b>New Castle, Delaware</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William C. Spencer</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Fluhardy</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WWI 212-18-0392</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED PERITONITIS</b> DUE TO <b>PERFORATED GASTRIC ULCER</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. <b>Coronary arteriosclerosis.</b> 2. <b>Old myocardial infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that <input checked="" type="checkbox"/> attended the deceased from June <b>21, 1957</b> , to July <b>9, 1957</b> . <b>XXXXXX-XXXX-XXXX-XXXX</b> and that death occurred at <b>9:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chien Wei Lan</i>				ADDRESS (Street, city or town, state) <b>M.D. VAH, FORT HOWARD, MARYLAND</b>			

DATE SIGNED  
**7/10/57**

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/13/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <b>John C. Miller Inc. - 2431-35 E Oliver St.</b>		ADDRESS <b>John C. Miller, Inc., 2435 E. Oliver St., Balt., Md.</b>	24a. REC'D BY REGISTRAR <b>15 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Devon of Farley</b>
---	--	--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 12 19

PAGE ONE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07252 31

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Item 9 Film G219 8-13-57 et  
**CERTIFICATE OF DEATH**

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>721 Sudbrook St</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Allegany Home</i>				d. STREET ADDRESS <i>721 Sudbrook St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Mary E. Spillman</i>		First <i>W</i>	Middle <i>E.</i>	Post <i>Spillman</i>	4. DATE OF DEATH <i>July 29, 1957</i>	Month <i>July</i>	Day <i>29</i>	Year <i>1957</i>		
5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 16, 1870</i>		AGE (in years last birthday) <i>86 yrs</i>	IF UNDER 1 YEAR <i>86 mos</i>	IF UNDER 24 HRS <i>86 hrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>				
13. FATHER'S NAME <i>George Jasiner</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Records Home 6811 Campfield</i>		Address <i>Records Home 6811 Campfield</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis (Recurrent)</i>		DUE TO <i>Arterio Sclerotic Heart Disease</i>		DUE TO <i>Generalized Arterio - Sclerosis</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>		(b)		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>450.0</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>—</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>	(State) <i>MD</i>	
21. I certify that I attended the deceased from <i>July 1, 1953</i> , to <i>July 29, 1957</i> , that I last saw the deceased alive on <i>July 25, 1957</i> , and that death occurred at <i>5:50 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Carl L. Chambers</i>		ADDRESS (Street, city or town name) <i>4108 Liberty St, Baltimore, MD</i>		DATE SIGNED <i>7-29-57</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 1, 57</i>		22b. DATE THEREOF <i>Aug 1, 57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Orange Cemetery</i>		22d. LOCATION (City, town or county) <i>Baltimore</i>		(State) <i>MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul Deeney</i>		ADDRESS <i>6067 Harford Rd</i>		24a. REC'D BY REGISTRAR <i>ANG 5 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Wm. Master</i>				

URLEAU V. S.

AUG 6 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07266

## CERTIFICATE OF DEATH

Reg. Dist. No.

07253

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>12yr10mth24dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>724 S. Ann Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Stanislaus</b>	Last	4. DATE OF DEATH <b>July 19 1882</b>	Month Day Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1882</b>	9. AGE (in years last birthday) <b>74 yrs</b>	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Parochial school</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
13. FATHER'S NAME <b>Jacob Skrzyniecki</b>		14. MOTHER'S MAIDEN NAME <b>Frances Golembiewska</b>		12. CITIZEN OF WHAT COUNTRY <b>Poland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) <i>Pulmonary emboli</i> DUE TO (c) <i>Myocardial degeneration + failure</i> <i>Arteriosclerosis + vascular disease</i> INTERVAL BETWEEN ONSET AND DEATH  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>Carcinoma of rt breast</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 26, 1956, to July 5 <sup>th</sup> , 1957, that I last saw the deceased alive on July 4 <sup>th</sup> , 1957, and that death occurred at <sup>AM</sup> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Gertude J. Fleischmann</i> M.D. SPRING GROVE STATE HOSPITAL 7.5.57 DATE SIGNED					
PHYSICIAN'S NAME (Type) <i>GERTRUDE J. FLEISCHMANN</i> Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-8-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>ST. STANISLAUS</b>	
22d. LOCATION (City, town, or county) <b>1300 DUNDALK AVE</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Weber 705 S. Ann St</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE 7.9.57	
				24b. REGISTRAR'S SIGNATURE <i>D. L. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal.

BUREAU V. S

JUL 9 1967

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07267

## CERTIFICATE OF DEATH

07254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN lb <b>lyrlmthlldys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>	d. STREET ADDRESS <b>22 Sanders Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary E. Wachsler</b>	First	Middle	Last
4. DATE OF DEATH <b>July 5 1957</b>	Month	Day	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 23, 1899</b>
9. AGE (In years from birthday) <b>57 yrs</b>		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Frederick List</b>		14. MOTHER'S MAIDEN NAME <b>Jinnie Gerlach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <b>Arteriosclerotic coronary occlusion</b>			
DUE TO			
(c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15</b> , 1957, to <b>July 5</b> , 1957, that I last saw the deceased alive on <b>July 5</b> , 1957, and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) <b>M.D. SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7-5-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 8, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Oaklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tickner &amp; Sons - North &amp; Pa Aves</b>		ADDRESS 24a. RECD BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the funeral director.

SAVANNAH

1951

GEORGIA

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7268

## CERTIFICATE OF DEATH

07255

Reg. Dist. No.

**HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, and be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYEVILLE</b>		c. LENGTH OF STAY IN 1b <b>1 MONTH 20 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME, 2815 KESWICK ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDITH ELLSWORTH</b>	First	Middle	Last <b>STONE</b>
4. DATE OF DEATH <b>JULY 20 1957</b>	Month	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-1-1879</b>
9. AGE (In years last birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13. FATHER'S NAME <b>CHARLES E. BURRIER</b>	14. MOTHER'S MAIDEN NAME <b>ANNA M. McCULLOUGH.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>213-03-47698</b>	17. INFORMANT <b>Frank L. Smith Jr.</b>	Address <b>Cockeysville, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
47-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<b>Cardiac Decompenstation due to</b>	
DUE TO (b) DUE TO (c)		<b>Arterio Sclerotic Cardiac Vascular disease</b>	
over 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) . (State)
21. I certify that I attended the deceased from <b>5/27</b> , 1957, to <b>7/19</b> , 1957, that I last saw the deceased alive on <b>7/19/57</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter J. Kees</i>	M.D.		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>
PHYSICIAN'S NAME (Type)	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-23-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook Inc 1217 SK PAUL SK</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>7-24-57</b>	24b. REGISTRAR'S SIGNATURE <i>Q. L. ...</i>

RECEIVED

BUREAU V. S.

JUL 9 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07258

43

07269

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)	
Baltimore MARYLAND		a. STATE Maryland	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN lb 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6708 Beech Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Franz L. Struhs		First Middle Last	4. DATE OF DEATH July 28, 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 2, 1880		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silversmith-Retired		10b. KIND OF BUSINESS OR INDUSTRY Silversmith	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Struhs		14. MOTHER'S MAIDEN NAME Wilhelmina Wallring	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-2912	
17. INFORMANT Mrs. Catherine Struhs		Address 6708 Beech Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO (b) Due to (c)  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH  cardiac arrest metastatic carcinoma 5 yrs prostatic cancer	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 16, 1957, to July 28, 1957, that I last saw the deceased alive on July 28, 1957, and that death occurred at 4 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. R. RIGLER		ADDRESS (Street, city or town, state) 1 W OVERLEA AVE BALTIMORE 6. MD. 7-30-57 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM St. Michael's Lutheran		22d. LOCATION (City, town, or county) Perry Hall, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kathleen L. Reynolds		24a. REC'D BY REGISTRAR DATE JUL 31 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE M. L. Reynolds	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUL 31 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07257

07270

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

BALTO.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BALTO, MD

c. LENGTH OF STAY IN 1b

19yr7mthldy

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

SPRING GROVE ST. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

BALTIMORE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

4 EX

d. STREET ADDRESS

Hamburger Avenue

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First GLADYS

Middle

Last STURTZ

4. DATE  
OF  
DEATH

Month 7

Day 7

Year 1957

5. SEX

FEM

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

4-24-1898

9. AGE (In years  
last birthday)  
yrs.

Months

10. IF UNDER 1 YEAR  
IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

IOWA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS L. NANCE

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

GUY STURTZ HUSBAND

Address

UNKNOWN

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION

INTERVAL BETWEEN  
ONSET AND DEATH

120.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b) DUE TO

(c) DUE TO

Arteriosclerotic coronary occluding  
Arteriosclerotic + hypertensive cardiovascular disease

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
While  
at work  Not while  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 7-7-57, 1957, to 7-7-57, 1957, that I last saw the deceased alive on 7-7-57, 1957, and that death occurred at 1:5 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Stella Wachsler

M.D.

SPRING GROVE STATE HOSPITAL 7-9-57

PHYSICIAN'S  
NAME (Type)

Stella Wachsler, M.D.

Catonsville 28, Maryland

22a. BURIAL/CREMATION  
✓ REMOVAL (Specify)22b. DATE THEREOF  
7-9-5722c. NAME OF CEMETERY OR CREMATORIUM  
Cem. of Med. Med. School22d. LOCATION (City, town, or county)  
Baltimore, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR  
JUL 10 1957

DATE

24b. REGISTRAR'S SIGNATURE  
C. Deacon

RECEIVED

JUL 11 1957

REGEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07271

## CERTIFICATE OF DEATH

03858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nursing Home</b>		d. STREET ADDRESS <b>1504 Marble Hall Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MAMIE</b>		First <b>H.</b>	Middle <b>SWEARER</b>	4. DATE OF DEATH <b>July 11, 1957</b>	Month <b>July</b>	Day <b>11</b>	Year <b>1957</b>
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>March 30, 1877</b>	9. AGE (In years lost birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months <b>80</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Annapolis, Md.</b>	
13. FATHER'S NAME <b>Charles Swearer</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Owen Tomlinson</b>		Address <b>Mr. Raymond R. Rever, R.F.D. #3, Melvin Rd.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)</b> <b>457X Stroke</b>		18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) <b>Cerebral Accident</b> <b>Hypertension</b>	
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>457X Stroke</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , 19, to <b>7/14/57</b> , that I last saw the deceased alive on <b>7/13/57</b> , 19, and that death occurred at <b>9:24 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>WALTER E. KARFGUY, M.D.</b>		ADDRESS (Street, city or town, state) <b>4231 Harford Rd.</b>		DATE SIGNED <b>7/16/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Green Mount Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Lickner &amp; Sons - Balt. 7, Md.</b>		ADDRESS <b>JUL 18 1957</b>		24a. REG'D BY REGISTRAR DATE <b>JUL 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Malv Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/55

BUREAU V. S

JUL 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07259

07135

## CERTIFICATE OF DEATH

Reg. Dist. No. 4V

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	c. LENGTH OF STAY IN 1b <i>48 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X?</i>	b. COUNTY <i>Baltimore</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ridge Avenue</i>	d. STREET ADDRESS <i>1 Ridge Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JOSEPHINE</i>	First <i>J</i>	Middle <i>A</i>	Last <i>ROBERT</i>		
4. DATE OF DEATH <i>May 12-1891</i>	Month <i>May</i>	Day <i>5</i>	Year <i>1891</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 12-1891</i>		
9. AGE (in years last birthday) <i>86 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	12. BIRTHPLACE (State or foreign country) <i>Austria</i>		
13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	14. FATHER'S NAME <i>STRUNZ</i>	15. MOTHER'S MAIDEN NAME <i>Unknown</i>	16. SOCIAL SECURITY NO. <i>420-1</i>		
17. INFORMANT <i>Federic V. Beiter</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Hypertension - Etiological Syndrome</i> (b) DUE TO <i>Diabetes mellitus</i> (c)	19. INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Overweight</i>	21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>✓</i>				
20c. TIME OF INJURY Hour a. m. <input checked="" type="checkbox"/> 19 p. m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>✓</i>	20f. (City or town) <i>✓</i>	(County) <i>✓</i>	(State) <i>✓</i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>AP</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Federic V. Beiter</i>	ADDRESS (Street, city or town, state) <i>M.D. 1014 Francis St. Baltimore Md.</i>	DATE SIGNED <i>July 1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial July 9-57</i>	22b. DATE THEREOF <i>July 9-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge</i>	22d. LOCATION (City, town or county) <i>Washington Blv. Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Federic V. Beiter</i>	ADDRESS <i>1014 Francis St. Baltimore Md.</i>	24a. REC'D. BY REGISTRAR DATE <i>July 9 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. Fred M. Ruffo</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

RUREAU V. G.

JUL 9 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07266

07272

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3  
**should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the funeral director.**

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>33 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1041 West Lanvale Street</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>SQUIRE</b>		First	Middle <b>M.</b>	Last <b>TAYLOR</b>	4. DATE OF DEATH July	Month	Day <b>30</b>	Year <b>1957</b>			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1887</b>		9. AGE (In years lost birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Rocky Mount, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>John Wesley Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Mary S. Smith</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give war or date of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>219-16-7891</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</b>  <b>199.9</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.      VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VA</b>		(County)	(State)		
21. I certify that attended the deceased from <b>June 27, 1957</b> to <b>July 30, 1957</b> , and that death occurred at <b>8:40A</b> M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>								<b>7/30/57</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>		VAH, FORT HOWARD, MARYLAND									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-1-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)			
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>		ADDRESS <b>Charles R. Law Mortuary, 802-01 Madison Ave.</b>		24a. REC'D BY REGISTRAR <b>Aug 2-57</b>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Parker</i>					

BUREAU V. S.

AUG 5 19

REGISTRATION

07261

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

M

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

07273

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN lb

2mths10dys

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

SPRING GROVE STATE HOSPITAL

3. NAME OF  
DECEASED  
(Type or print)

First  
Minnie

Middle  
Emilia

Thom

4. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

female

white

WIDOWED

DIVORCED

Dec. 13, 1874

9. AGE (in years  
at birthday)

82

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housekeeper

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

Germany

13. FATHER'S NAME

August Thom

14. MOTHER'S MAIDEN NAME

Augusta Mielke

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Address

Records: SPRING GROVE STATE HOSPITAL

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

903.7

Acute cardiac failure

Conditions, if any, which  
gave rise to immediate cause  
(a), showing the underlying  
cause lost.

(b)

DUE TO

DUE TO

(c)

Raynaud's vascular disease

fracture left femur

accident

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

4

INTERVAL BETWEEN  
ONSET AND DEATH

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) While walking on ward,

pt. fell to floor, sustaining fractured left femur

MEDICAL CERTIFICATION

20c. TIME OF INJURY Month, Day, Year

Hour

a. m.

10:15

7-9

19 57

20d. INJURY OCCURRED

While

Not while

of work

of work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Citonsville 28, Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

22e. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22f. DATE THEREOF

7-31-57

22g. NAME OF CEMETERY OR CREMATORIUM

Honden Park

22h. LOCATION (City, town, or county)

Baltimore

DATE SIGNED

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Deacon

ADDRESS

4107 Webster

24a. REC'D BY REGISTRAR

July 31 '57

24b. REGISTRAR'S SIGNATURE

Allie Finch

RECEIVED  
BUREAU X

JUL 31 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07262

## 07274 CERTIFICATE OF DEATH

Reg. Dist. No. 33-

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3  
 If be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Baltimore</i>		<i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <i>50 yrs.</i>	
<i>Millers, Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Beckleysville Rd.</i>		<i>Beckleysville Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Ethel</i>		<i>M.</i>	<i>Tracey.</i>
4. DATE OF DEATH		Month	Day
		<i>July</i>	<i>18</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>F</i>		<i>W</i>	<i>B. DATE OF BIRTH</i> <i>Dec. 4, 1893</i>
8. AGE (In years lost birthday)		9. IF UNDER 1 YEAR	10. IF UNDER 24 HRS.
<i>63 yrs</i>		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Laborer</i>		<i>Canning Factory</i>	<i>Freeland, Md. R.R. U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Irvin McCullough</i>		<i>Sarah Cole</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
(If yes, give war or dates of service)		<i>183-188-03A</i>	<i>James W. Tracey, Millers, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>4/2</i>		<i>24 hr</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		<i>Great Fall Fever or typhus.</i>	
DUE TO (b)		<i>Ch. Valenzas Cardiac Disease</i>	
DUE TO (c)		<i>(Postic)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at play <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
<i>in bed</i>		<i>Baltimore</i>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. R. Bowers</i>		ADDRESS (Street, city or town, state) <i>7117 Madison</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>7/17/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 21, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Fine Gravelly</i>		22d. LOCATION (City, town, or county) (State) <i>Parkton, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Hartenstein New Freedom</i>		24a. REC'D BY REGISTRAR DATE <i>7/20/57</i>	
ADDRESS <i>Par</i>		24b. REGISTRAR'S SIGNATURE <i>Colchester of Fadde</i>	

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RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07263

Reg. Dist. No.

33-

1  DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
 2 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Baltimore</i> <small>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</small> <i>Rural - White Hall</i>		<small>c. LENGTH OF STAY IN 1b</small> <i>37 yrs.</i> <small>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</small> <i>Meredith Rd.</i>	
<small>3. NAME OF DECEASED (Type or print)</small> <i>Stella Agnes</i>		<small>First</small> <i>Stella</i>	<small>Middle</small> <i>Agnes</i>
<small>4. DATE OF DEATH</small> <i>July 3 1957</i>		<small>Last</small> <i>Trout</i>	<small>Month</small> <i>July</i>
<small>5. SEX</small> <i>F</i>		<small>6. COLOR OR RACE</small> <i>W</i>	<small>7. MARRIED</small> <input checked="" type="checkbox"/> <small>NEVER MARRIED</small> <input type="checkbox"/> <small>WIDOWED</small> <input type="checkbox"/> <small>DIVORCED</small> <input type="checkbox"/>
		<small>8. DATE OF BIRTH</small> <i>Aug. 16 1899</i>	
<small>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</small> <i>Housewife</i>		<small>10b. KIND OF BUSINESS OR INDUSTRY</small> <i>Own home</i>	
<small>10c. BIRTHPLACE (State or foreign country)</small> <i>Stewartstown, Pa.</i>		<small>12. CITIZEN OF WHAT COUNTRY?</small> <i>U.S.A.</i>	
<small>13. FATHER'S NAME</small> <i>Joseph Waltemyer</i>		<small>14. MOTHER'S MAIDEN NAME</small> <i>Margaret Sheffer</i>	
<small>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)</small> <i>No</i>		<small>16. SOCIAL SECURITY NO.</small> <small>17. INFORMANT</small> <i>Maurice Trout - White Hall, Mrs.</i>	
<small>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</small> <small>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</small> <i>400.1</i>		<small>INTERVAL BETWEEN ONSET AND DEATH</small> <i>3 min</i>	
<small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</small> <small>(b)</small> <small>DUE TO</small> <small>(c)</small>		<small>coronary occlusion</small>	
<small>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</small>		<small>19. WAS AUTOPSY PERFORMED?</small> <small>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small>	
<small>20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</small>		<small>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</small>	
<small>20c. TIME OF INJURY</small> <small>Month, Day, Year</small> <small>Hour o. m.</small> <small>p. m.</small>		<small>20d. INJURY OCCURRED</small> <small>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></small>	
		<small>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</small> <small>20f. (City or town)</small> <small>(County)</small> <small>(State)</small>	
<small>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</small>			
<small>ACTUAL SIGNATURE</small> <i>A. M. France</i>		<small>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></small> <small>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></small> <small>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></small>	
<small>EXAMINER'S NAME (Type)</small> <i>A. M. France</i>		<small>22a. BURIAL, CREMATION, REMOVAL (Specify)</small> <i>Burial</i>	
		<small>22b. DATE THEREOF</small> <i>7/6/57</i>	
<small>22c. NAME OF CEMETERY OR CREMATORIUM</small> <i>New Freedom Cemetery</i>		<small>22d. LOCATION (City, town, or county) (State)</small> <i>New Freedom, Pa.</i>	
<small>23. FUNERAL DIRECTOR'S SIGNATURE</small> <i>Frank Hartman, Jr.</i>		<small>24a. REC'D BY REGISTRAR</small> <small>DATE</small>	
		<small>24b. REGISTRAR'S SIGNATURE</small> <i>Charles L. Peden</i>	

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07264

Reg. Dist. No. 38

07276

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PHM3. Page 5 may be retained for your records.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; removal, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>M d.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>		b. COUNTY <b>Balto.</b>	
c. LENGTH OF STAY IN 1b <b>65 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stella Maris Hospice, Dulaney Valley</b>		d. STREET ADDRESS <b>840 N. Chapelgate Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Marie J. Twamley Middle</b>		4. DATE OF DEATH Month Day Year <b>July 30, 1957</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 19, 1873</b>	
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>Lane</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Stolba</b>		14. MOTHER'S MAIDEN NAME <b>Josephine —</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mrs. Florence Cummings, 840 N. Chapelgate</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b>		Address <b>Sudden</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Phlebitis left leg</b>		INTERVAL BETWEEN (b) AND DEATH <b>24 Hrs.</b>	
DUE TO (b) <b>Fractured Hip (Right)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Immobilization for Fractured hip Caused Phlebitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Walking down Hall Slipped &amp; fell on hip</b>	
20c. TIME OF INJURY Month, Day, Year <b>How 8 p.m. 6/15/57</b>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Towson Baltimore Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		DATE SIGNED <b>7/31/57</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 3/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Loudon Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore 29 Ma.</b>	
23a. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>AUG 2 1957</b>	
23b. ADDRESS <b>Edmondson</b>		24b. REGISTRAR'S SIGNATURE <b>Mobile Gray</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07265

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 313 Liberty Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Herman	Middle A.	Last Ulbig, Sr.	4. DATE OF DEATH	Month July Day 4 Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME Augustus Ulbig			14. MOTHER'S MAIDEN NAME Ella Hennon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown			16. SOCIAL SECURITY NO. 219-01-7610	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary emboli</i>			INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>434.5</i>			DUE TO (b) <i>Cardiac decompensation</i> — 2 months (c) <i>Generalized severe arteriosclerosis</i> unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 434.5		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Gentriale J. Fleischman	(County)	(State)
21. I certify that I attended the deceased from May 28, 1957 to July 4th, 1957, that I last saw the deceased alive on July 4th, 1957, and that death occurred at 5:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Gentriale J. Fleischman</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANA Catonsville 28, Maryland DATE SIGNED 7.4.57					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>July 7, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore</i>	22d. LOCATION (City, town, or county) <i>North Ave Est</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leo Fleischman</i>	ADDRESS <i>150 Patterson Park Ave.</i>	24a. REC'D BY REGISTRAR <i>JUL 10 1957</i>	24b. REGISTRAR'S SIGNATURE <i>R. L. Smith</i>		

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1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07266  
14

07279

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <i>1-1-1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>73 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>24 Dunkirk Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MICHAEL</b>	Middle <b>A.</b>	Last <b>VICARI</b>	4. DATE OF DEATH <b>July 5 1957</b>	Month <b>July</b>	Day <b>5</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>9/20/03</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Timekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fruit Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vincent Vicari</b>				14. MOTHER'S MAIDEN NAME <b>Mary Max</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-01-9066</b>		17. INFORMANT <b>Clin. Rec. Div., Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>			
39IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH THAT NOT RELATED TO THE TERMINAL DISEASE CONDITION <b>Chronic bronchial asthma. Chronic pulmonary emphysema. Atherosclerotic cardiovascular disease. Pneumonia</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>141X</b>					
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	Day	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>7/6/57</b>	(County)	(State)
21. I certify that I attended the deceased from April 23, 1957, to July 5, 1957, at <b>6009 Harford Road</b> , and that death occurred at <b>4:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>7/6/57</b>							
ACTUAL SIGNATURE <i>Roland P. Ponce de Leon</i> M.D. PHYSICIAN'S NAME (Type) <b>ROLANDO P. PONCE de LEON</b> Fort Howard, Md. 7/6/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-9-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Joseph's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Texas, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Bright Inc 6009 Harford Road</b>		ADDRESS <b>6009 Harford Road</b>		24a. REC'D BY REGISTRAR DATE <b>7/6/57</b>	24b. REGISTRAR'S SIGNATURE <i>Savon L. Farley</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08352

07278

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4yr9mth9dys</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>Greenspring Avenue</b>					
3. NAME OF DECEASED (Type or print) <b>Walter</b>		Fist <b>Gilbert</b>	Middle <b>Wadsworth</b>				
4. DATE OF DEATH <b>July 31 1957</b>		5. LAST NAME <b>Wadsworth</b>	Month Day Year Year				
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1879</b>				
		9. AGE (In years (last birthday) <b>78 yr.</b>	10. IF UNDER 1 YEAR Months <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Samuel Wadsworth</b>	14. MOTHER'S MAIDEN NAME <b>Mary Alice Wadsworth</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH					
4 d 2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>ox</b>					
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>19</b>	Year <b>1957</b>	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SPRING GROVE STATE HOSPITAL</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>7-31-57</b>	(State)
21. I certify that I attended the deceased from <b>July 1, 1957</b> , to <b>July 31, 1957</b> , that I last saw the deceased alive on <b>July 31, 1957</b> , and that death occurred at <b>10:25pm</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Bruno Radauskas M.D.</b>				DATE SIGNED <b>7-31-57</b>			
ACTUAL SIGNATURE <b>Bruno Radauskas</b>		PHYSICIAN'S NAME (Type) <b>Bruno Radauskas</b>		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/6/57</b>	22b. DATE THEREOF <b>8/6/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Univ. of Md. Anatomy Board</b>	22d. LOCATION (Cty., town, or county) <b>Baltimore 295, Green St.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Your M.D. (Anatomy) 295, Green</b>	ADDRESS <b>14th &amp; 29th Streets</b>	24a. REC'D BY REGISTRAR DATE <b>8/6/57</b>	24b. REGISTRAR'S SIGNATURE <b>Hallie Findele</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the body of the certificate and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.  
RECEIVED  
1957

FOR STATE

HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the S.C. Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2.57tem 18 Film 218 8-  
07280 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07267

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>
--	----------	---

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**Catonsville**

c. LENGTH OF STAY IN lb

**3 years**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

**Spring Grove State Hospital**

3. NAME OF

First

Middle

(Type or print)

**Annie****NM**

Last

**Webb**4. DATE  
OF  
DEATHMonth **July** Day **20**, Year **1957**

5. SEX

**Female**

6. COLOR OR RACE

**White**7. MARRIED NEVER MARRIED 

8. DATE OF BIRTH

**1910**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**none**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Samuel Webb**

14. MOTHER'S MAIDEN NAME

**Kate Loos**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

**no**

16. SOCIAL SECURITY NO

**none known**

17. INFORMANT

Records: Spring Grove State Hospital

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] **failure of heart**  
 PART I. DEATH WAS CAUSED BY: **Congestive heart failure** *(Philadelphia)*  
 IMMEDIATE CAUSE (a) **351X**  
 DUE TO **Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.**  
 (b) **Arterio sclerotic narrowing of left coronary**  
 DUE TO **(c) Congenital cerebral spastic paraplegia**

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

**Sudden death while eating meal; no signs of injury**19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20c. TIME OF INJURY Month, Day, Year  
Hour a. m. **19** p. m.20d. INJURY OCCURRED While at work  Not while at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes  Accident , Suicide , Homicide , Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)**George M. Kieffer, M.D.**M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

DATE SIGNED

**7/20/57**22a. BURIAL, CREMATION  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE **AUG 2 '57**

24b. REGISTRAR'S SIGNATURE

DATE **Aug 2 '57****J. J. Zahra & Sons 1318 High St****Alfred Kieffer**

BRUNAU V. 8

23 2 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07281

## CERTIFICATE OF DEATH

07268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>3311 Liberty Heights Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Emilie</b>	Middle <b>Von de Hyde</b>	Last <b>Weber</b>	4. DATE OF DEATH <b>July 8</b>	Month <b>July</b>	Day <b>8</b>	Year <b>19 57</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>October 17, 1873</b>	9. AGE (in years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY: <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown Von de Hyde</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 422.1 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>June 25</b> , 19 <b>57</b> , to <b>July 8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>July 8</b> , 19 <b>57</b> , and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Stella Wachsler</i>	ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>						DATE SIGNED <b>7-8-57</b>
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>	Catonsville 28, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/11/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn Cem.</b>	22d. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. M. J. Dickner &amp; Sons - Baltor, Md.</i>	ADDRESS <b>JUL 10 1957</b>	24a. REC'D BY REGISTRAR <b>JUL 10 1957</b>	24b. REGISTRAR'S SIGNATURE <b>JUL 10 1957</b>				

BUREAU V. S

JUL 10 1967

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07269  
07282 CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CITY (If outside corporate limits, write RURAL OR nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
BALTO. Gwyn Oak	2 yrs	BALTO.	ROSELAWN AVE
HOSPITAL OR INSTITUTION OR STREET ADDRESS	AUGSBURG Home		
3. NAME OF DECEASED (Type or Print)	(First) ADOLPH F	(Middle)	4. DATE (Month) (Day) (Year)
5. SEX: M.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH: Oct 30, 1867
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY: RETIRED	9. AGE last birthday: 90 yrs	11. BIRTHPLACE (State or foreign country): BALTIMORE
13. FATHER'S NAME: ADAM. WENDEL	14. MOTHER'S MAIDEN NAME: ELIZ.	12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS: 6811 CAMPFIELD Rd Records AUGSBURG HOME	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.0			
IMMEDIATE CAUSE: (A) DUE TO: Broncho - Pneumonia.			
ANTECEDENT CAUSE (S): (B) DUE TO: Arterio - Sclerotic Heart Disease.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
Generalized Arterio - Sclerosis 5 yrs			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
4 yrs		2 wks	
4 yrs		4 yrs	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDULFYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAM NFR)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 14, 1957, to July 23, 1957, that I last saw the deceased alive on July 24, 1957, and that death occurred at 11:20 M. from the causes and on the date stated above.			
SIGNATURE: <i>John L. Chambers</i> ADDRESS: M.D. 4108 Liberty St. • Balto. Md. DATE SIGNED: 7/23/57			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY): BURIAL		NAME OF CEMETERY OR CREMATORIUM: Parkwood	
DATE REC'D BY LOCAL REGISTRAR: 7/24/57		LOCATION (U.S., TOWN, OR COUNTY): BALTO. MD	
REGISTRAR: <i>John E. Martin</i>		24. FUNERAL DIRECTOR: PAUL A. HEEMANN	
		ADDRESS: 6067 Harf Rd.	

THE GENEVA  
CONFERENCE

July 25 1957

CONFERENCE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07283

## CERTIFICATE OF DEATH

07270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Monkton</i>		c. LENGTH OF STAY IN 1b <i>3 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Big Falls Rd</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. STREET ADDRESS <i>2225 North Howard</i>		d. STREET ADDRESS <i>2225 North Howard</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sarah Elizabeth Williams</i>		First <i>Sarah</i>	Middle <i>Elizabeth</i>
4. DATE OF DEATH <i>July 12 1957</i>		Month <i>July</i>	Day <i>12</i>
5. SEX <i>Fem ale</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>2 Sept 1879</i>
8. DATE OF BIRTH <i>2 Sept 1879</i>		9. AGE (In years lost birthday) <i>77 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Hereford, Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Edward Stevenson</i>		14. MOTHER'S MAIDEN NAME <i>Sally Kelly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Doris Newmuis</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>one year -</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> While at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1957</i> to <i>July 1957</i> , that I last saw the deceased alive on <i>July 1957</i> , and that death occurred at <i>3:45 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D. ADDRESS (Street, city or town, state) <i>Cocheysville</i> DATE SIGNED <i>12 July 57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/16/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lukes</i>		22d. LOCATION (City, town, or county) (State) <i>Hereford, Balto. Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Kees</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 19 1957</i>	
24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, to be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BILBAU V. S

11. 7. 1957

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG218 7-23-57 et

7284

0727A

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Essex, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>	c. LENGTH OF STAY IN 1b <b>54</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>/ Thompson, Blvd.</b>		d. STREET ADDRESS <b>/ Thompson, Blvd.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Barbara</b>	First <b>M.</b>	Middle <b>Winkelman.</b>	4. DATE OF DEATH <b>July 14, 1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 31, 1865</b>
9. AGE (In years from birthdate) <b>91</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>None</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Harry C. Winkelman, Thompson Blvd. Essex.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Subacute</b>	
170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Arteriosclerotic Cardiovascular Disease</b>		DUE TO <b>3 yrs</b>	
DUE TO <b>Carcinoma left Breast</b>		DUE TO <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 14, 1957</b> to <b>July 14, 1957</b> that I last saw the deceased alive on <b>July 14, 1957</b> , and that death occurred at <b>54</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore Md.</b>		DATE SIGNED <b>7/14/57</b>	
ACTUAL SIGNATURE <b>J. M. Bumgardner</b>		PHYSICIAN'S NAME (Type) <b>M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/18/57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) <b>Eastern Ave.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek Funeral Home</b>		24a. REC'D BY REGISTRAR <b>1111 16105</b>	24b. REGISTRAR'S SIGNATURE <b>Edith Harley</b>
3331 Brehms Lane. <b>Charles E. Schimunek,</b>			

WISCONSIN STATE POLICE DEPARTMENT - MILWAUKEE 10  
CERTIFICATE OF DATA

BUREAU V. S

JUL 16 1957

REGISTRAR

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7285)

## CERTIFICATE OF DEATH

07272

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Baltimore MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓	
3. NAME OF DECEASED (Type or print)		First	Middle
Elizabeth L.			Wright
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 22, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		—	Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Ely Lilley		Eleanor Hyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
no			Edward Lee Wright 9 Wyndcrest Ave. (28)
Address			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5 min	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } DUE TO { (b) DUE TO (c) Hypertension		years	
Arteriosclerosis		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 447X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>July 2, 1957</u> , that I last saw the deceased alive on <u>July 1, 1957</u> , and that death occurred at <u>7 pm</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town/village)	
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type)		1118 St. Paul St. - 7/3/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-5-1957	22c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park
22d. LOCATION (City, town, or county) Woodlawn		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3207 W. North Ave.	24a. REC'D BY REGISTRAR DATE JUL 5 '57
			24b. REGISTRAR'S SIGNATURE Rebel

CHIEF OF STAFF CECILIA H.

BUREAU V. S.

JUL 5 1957

RECEIVED